TRADITIONAL HEALTH BELIEFS AND PRACTICES OF POSTNATAL WOMEN IN TRINIDAD

By

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For Professor Syam Roopnarinesingh
who admitted me into Mt. Hope Women's Hospital to conduct my research,

for Sister Saiisha Mohammed-Ragoo who nursed me during my incubation period at the postnatal ward,

and for all the grandmothers, mothers and masseuses who nurtured the birth of a research idea that I had conceived with my wife

[Do] you think if a doctor can't cure you, he will tell you? He will eat all you money. He would never send you by me. He would say, "Them old woman eh [don't] know nothing."

— 70- year-old traditional masseuse in Trinidad, 1995.

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The purpose of this ethnographic study is to describe and analyze traditional health beliefs and practices of postnatal women in a multi-ethnic urban setting in the economically developing country of Trinidad (and Tobago). Not much is known about the existence of traditional health care services which continue to be utilized even when modern sources of medical aid are available. Postnatal women in Trinidad seek health care from biomedical practitioners, older family members, and masseuses in the community. This study examines areas of consonance and dissonance (i.e. symptomology, etiology, treatment, diagnosis and prevention) between biomedical and traditional systems of medicine. The two systems are presented in the context of larger racial, ethnic, class, and gender relationships in which issues of power, control and dependency arise. The study is located in the political-economic context of the Third World which has a history of

dependency on foreign goods and services rooted in the plantation economy The implications of this study for primary health care is also discussed Quantitative and qualitative data for this research were collected through a wide range of methodologies including participant observation, photographic recording, semi-structured interviewing, and the chronicling of personal life-histories

CHAPTER 1
INTRODUCTION

The Structural Adjustment Policies (SAPs) implemented by developing countries like Trinidad (and Tobago)[1] in the 1980s have severely affected those at, and below, the poverty line, especially the vulnerable groups of women, children and elderly people (PAHO/WHO 1994, Safa and Antrobus 1992). These policies prescribed by the World Bank and the International Fund (IMF) for addressing balance of payments problems, brought about alarming increases in health care costs with the result that biomedical health care services are now outside the reach of large sections of the population (Phillips 1994). In a study (READ 1989) undertaken in Trinidad on diabetes it was shown that traditional or home remedies were used along with cosmopolitan medicine, even though diabetics reported that they were warned against the use of home remedies by health professionals. The study predicts that shortages of medication, increasing prices, and diminishing household incomes are likely to cause more women than men to resort to use of traditional remedies.

In developing countries, women are the main providers of health care in their households, in biomedical facilities (as nursing and support personnel) (Marieskind 1980), and in traditional health care systems (as traditional birth attendants) (Turshen 1991). Graham (1985:25-26) states quite appropriately that

> informal health care has remained part of the domestic economy, molded by the relations which govern everyday

> life in the family and community. In particular it is seen to be shaped by two convergent sets of social relations: first, by a sexual division of labor in which men make money and women keep the family going, and second by a spatial division of labor whereby the community becomes the setting for routine care and maintenance and the institutions of medicine are the location for the acquisition and application of specialist skills. These two dimensions have been closely related historically, with the process of male domination converging with the process of professionalization to define the health work of women.

Women invariably act simultaneously as primary providers, negotiators, and mediators of health within the home (Antrobus 1993, Graham 1985). In their time-consuming multiple roles as producers and reproducers, women are given the additional burden of making a decision on which type of health care resource to utilize.

The dearth of literature on the health-seeking behavior of Caribbean women, and the sources of informal health care which they provide, have contributed to their muteness and invisibility in formal discourse. Compilers of health data have consistently limited their concerns to biomedical practitioners and the facilities in which they operate. There is the need therefore, to study all health care systems in developing countries to determine how low-income women cope with their own illnesses, and those of family members, in communities that are, or are becoming increasingly "modernized" (see Mesa-Lago 1992).

Problem and Rationale

In the 1980s, Caribbean Governments implemented SAP's as a result of balance of payments problems in their developing economies. These policies had negative effects on national employment, income levels, food prices,

social infrastructure, education and housing. Additionally, there were specific reductions in public expenditures for health care and the subsequent increase in the privatization of health care services.

The implementation of these policies caused alarming increases in health care costs. As a result, the responsibility for health care was shifted from the state to the household, which further increased the burden on women "who have always assumed a primary role in household survival strategies" (Safa and Antrobus 1992:50; see also Phillips 1994). In Trinidad, the health and social services received smaller financial allocations between 1982 and 1990, which resulted in a decrease of 54 percent in the real value of the resources allocated to the health sector (PAHO/WHO 1994:414).[2] Generally, shortages in these plantation-modeled economies are not met by drawing on local resourcefulness, but rather by further economic dependence on supplies and technologies imported from industrialized countries (Beckford 1975).

Sinha (1988:147) argues that in the Caribbean, health care services available to mothers and their neonates are not utilized when compared to antenatal services. He adds that postnatal services are provided at hospitals, health centers, "and in many cases at homes." While information on postnatal services provided at biomedical institutions is readily available, there is little documentation of the nature of the services provided at home. Since Sinha equates "care" with biomedical care, and does not extend his definition to traditional care, he (Sinha 1988:150) arrives at the erroneous conclusion that "very few mothers receive adequate post-natal care in the six weeks after they give birth." Sinha is simply reproducing the mistake of many of his predecessors. For example, researchers (PAHO 1976:9) on Maternal and Child Health (MCH) in the late 1970s conclude that

> [t]hroughout the Caribbean, *care of the mother during the postnatal period is very unsatisfactory* The postnatal period should be considered as a crucial stage of the MCH cycle for both mother and child contacts with the mother can provide an excellent opportunity to educate her about health needs--her own and the infant s, child spacing, and family planning Therefore the development of postnatal services should be greatly emphasized [emphasis added]

Since hospitals in Trinidad do not have the resources to keep postnatal women in the hospital for the stipulated 48 hours after delivery those who have had "normal deliveries are discharged after 24 hours According to biomedical practitioners, early discharge subjects a woman to certain risks For example physical complications may occur, which can include discomfort at an episiotomy or cesarean incision site, endometritis and mastitis. Physiologic changes can also be affected such as uterine involution, increased edema and hyperemia of the bladder with possible atrophy, and diuresis may occur The patient may confront other changes, such as fatigue, problems in meeting the needs of har infant, role conflict, and adjustment within parental and family relationships

> Early hospital discharge means that many of the nurturing and infant care skills previously taught by health professionals are now crammed into a short time frame just prior to hospital discharge, when the client s attention is often focused on what awaits har at home. (Youngkin and Szmania 1994 520)

The puerperium is a time when professional assistance and instruction are expected to be given in the hospital so that the parents may return home with reasonable competence and confidence (AAP & ACOG 1992:91) The shortage of nurses in Trinidad has made it difficult for them to visit the homes of new parents regularly Accordingly, nurses do not have the opportunity to discuss postpartum problems or provide guidance, support, advice and reassurance

One research team (PAHO 1985:56) has pointed out that the maternal

health care situation in Latin America and the Caribbean countries is difficult to describe." It adds that while data are available on the numbers of doctors and other health professionals, clinics, health establishments, and hospitals, "there are other resources on which only partial information is available." This study is exactly about those "other resources" that are provided at home and in the community to postnatal women and their neonates after they have been discharged from biomedical institutions. Few health care providers possess a clear idea of the extent to which traditional healing is still being practiced. The aim of this research project is to delineate the relationships between two major medical systems and to identify the roles that each system plays in the health care of parturient women in particular, and patients in general.

The objective of this research is to document, describe and analyze folk medical traditions in Trinidad as they relate to the care of postnatal women and their neonates. Emphasis is placed on the masseuse-patient interaction as part of the total medical health care system. I also attempt to describe and analyze how the biomedical system impacts on the traditional medical system, and to examine the extent of the retention of traditional beliefs and practices among different generations of women cross-culturally. A study of this nature should provide biomedical practitioners with the basis for understanding and promoting the welfare of the new mother and her infant in a developing country in which the government's expenditure on health care is decreasing. This information should also provide a means by which medical practitioners would become familiar with the cultural background of their ethnically diverse parturient female patients. This understanding should facilitate the formulation of a culturally sensitive health care program

in which local health planners can consider the incorporation of more traditional practices in their biomedical regimens.

Medical Pluralism

Traditional, folk or vernacular systems of medicine rely largely on oral tradition and apprenticeship for the teaching of their tenets and the training of their practitioners (Hufford 1988, O'Connor 1995). Traditional medicine is dynamic, and not static, because it is located within a large national context in which the forces of the politically dominant culture have penetrated over time (Romanucci-Ross 1983). In the "little tradition" of folk medicine, knowledge of health and illnesses is not codified, but is widely shared between users and practitioners (Press 1978:72). Traditional medical systems articulate theories of disease etiology and remediation within a larger cultural framework of moral, ethical, religious, and supernatural concerns. The underlying causes of illnesses are generally seen as some kind of imbalance or lack of harmony in the body, the social environment, the spiritual world or the cosmos. A complex, multi-causal view of illness etiology and appropriate therapeutics allows the sufferer to bring the maximum number of resources to bear on his complaint and provides a rationale not only for treatment but for efforts at prevention, such as protective amulets, blessings and pilgrimages, good diet and exercise (Hufford 1988).

Traditional medical systems are more open than other systems and their therapeutics, therefore, are more likely to include substantial imputs of biomedicine in their repertoires. Religious and charismatic healing belongs to the folk medical system because therapy is effected by means of prayers to, and faith in, a supernatural being.[3] Traditional health care conventions in Trinidad have sprung mainly from the folk medical systems of India and

Africa where immigrant laborers were uprooted and transplanted to the sugar plantations in the New World

I apply the classification "popular or alternative medicine" to medical systems relying significantly on print and other forms of media and frequently having formal organizations and curricula for participant instruction or practitioner training (e.g. naturopathy or chiropractic) (O'Connor 1995). The alternative medicine sector, of which the "health food movement" is the best example, has enjoyed steady growth over the past 20 years in developed countries (Hufford 1988). Some commentators believe this trend signifies an important change in values, a reaction against a materialistic age, a desire to return to a more "natural" lifestyle and a belief that a state of total health is achievable through personal preventive actions. Others view the movement more narrowly as an expression of dissatisfaction with the scientific and technological dominance of modern science (Murray and Shepherd 1993).

The official health care system is referred to by a range of terms, of which some very common ones include "biomedicine," "scientific medicine," "modern medicine," "orthodox medicine," "regular medicine," "conventional medicine," "organized medicine," and "cosmopolitan medicine." The officially sanctioned medical system is based on Western science and technology, and it is the form of medicine that is controlled by the ruling class. In keeping with the scientific tradition, its practitioners have striven to separate themselves from broader social and cultural concerns and influences. Its concepts and methods have become universal in application and are not altered significantly by different ecological environments. Its practitioners discount religious, metaphysical, and philosophical considerations from their explanatory models of disease and dysfunction

(O'Connor 1995) Though scientific medicine has its roots in traditional practice its practitioners are "rather embarrassed" by it (Vaskilampi and MacCormac 1982-v)

Basically, there are two systems of health care in the developing world one is traditional and the other is Western in derivation Modern medical services constitute the politically dominant form of health care in Trinidad's health care program. Perhaps the most distinctive feature of the growth of health services in Third World countries, like Trinidad, is that these services have been promoted by affluent capitalistic countries (Banerji 1984) The increasing commercialization of health-related products (Banerji 1984) and the demonstrated power of science and technology (Singer 1989) beamed through satellite television stations are convincing people of the magic of western medicine At the national level,

> [t]he modern system of medicine enjoys the approval, cooperation, and protection of the country's legal system and other supporting social institutions government licensing and regulatory bodies, third party payment systems, preferred access to federal and private and research monies, high prestige social status and their concomitant benefits, including professional associations with substantial lobbying power and professional publications with influential reputations for authority (O'Connor 1995 5)

The state-supported modern medical system, which tends to be synonymous with a monopolistic medical "establishment" and a doctor-dependent, hospital-based, curative health care model, does not generally recognize, cooperate with, or adjust to the traditional medical systems (Good *et al* 1979-141) The two exist side by side, yet remain functionally unrelated in any organizational sense There is the belief that with the recognition of traditional medicine and the political commitment to humanistic health care reform, better use of scarce resources for the common good can be made

Techniques and medications of modern practice are increasingly filtering down to local healers. Folk, popular and orthodox medical practices may coexist, compete and intermingle with one another within a single community, nation or region. Indeed many traditional or popular health beliefs may be supported, reinforced or rejected by biomedical explanations. The combined use of both types of expertise provides an optimal broad-spectrum response to health problems. "Medical pluralism offers a variety of treatment options that health seekers may choose to utilize exclusively, successively, or simultaneously" (Stoner 1986:46). People may try a variety of practitioners and treatments, from the same or different systems, until a cure results. In many societies (see, e.g. Morsy 1993), the continuing process of negotiation takes place as patients seek therapies and etiologies consistent with their understandings of illness. Patients may accept some aspects of the scientific health care system as presented to them by a government physician, and they may supplement this with information gathered in consultation with traditional healers (see Staino 1981). The systems differ in availability, quality of care, levels of technology, and social adaptability; yet, ideally, both are intended to serve the same population in need.

Traditional or local medicine still remains an important source of medical care in the developing countries even though it is not officially recognized by the government health care programs (Jaspan 1969, Kleinman 1980). It persists in urban as well as rural settings despite the availability of allopathic health services. I have found in Trinidad, however, that its general persistence is decreasing in importance over generations, particularly among socially isolated nuclear families. In traditional medical systems worldwide, afflictions which beset body and mind can be explained in both naturalistic and supernaturalistic terms. When a wound does not heal, when a sickness

does not respond to treatment, and when the normally expected and predictable does not happen, other explanations beyond the organic are sought (Hughes 1978) The rise in status of folk healing systems in capitalistic countries is contingent upon gaining "acceptance from strategic elites who are seeking solutions to the contradictions of capitalistic-intensive medicine and/or by patients who demand forms of treatment neglected by orthodox medicine' (Baer 1984.3)

The Informal Health Care Sector

The wide spectrum of activities in the informal sector in developing countries makes this sphere difficult to define. These activities are performed by an "invisible" group of workers whose members are neither working in the modern organized sector nor formally unemployed (Thomas 1995 10) The main characteristics of the informal sector are ease of entry, reliance on local resources, family ownership of enterprises, small-scale operations, labor-intensive work, use of adaptive technologies, use of skills acquired outside a school, and an irregular and competitive market In most cases, it is a form of survival or economic-independence for its operators which requires little or no capital. This sector has untapped development potential, especially in the face of stagnant growth and rising unemployment. These units are not registered (that is outside national accounting labor legislation, and social protection) and taxes are not paid (ILO 1995, Merrick and Schmink 1983) The survival of traditional (primitive) activities and methods of production that would (and should) disappear in the process of increased industrialization and modernization" (Thomas 1995 11) can appropriately

include the work of traditional healers like shamans bone-setters, priests, spiritual healers, and midwives

Shamans in Trinidad are called *obeahmen* and are usually men of different ethnic backgrounds (Niehoff and Niehoff 1960, Vertovec 1992)[4] who claim to have direct contact with spirits whom they can invoke for good or evil. They are feared for their mysterious occult powers which include the ability to transfer ailments by magical means to other persons. They are sought to reveal the source, cause and cure of certain physical, psychological phychiatric social and legal problems. Unlike doctors, shamans generally provide culturally satisfying explanations of the causes of a patient's afflictions. The affected person may be given an opportunity to participate in his own treatment through curative rites or by procuring the magical ingredient(s) himself. They serve a wide inter-ethnic lower-income group of clientele for a price. Religious figures, like those of the Orisha, Spiritual Baptist and Hindu faiths,[5] may cross thet nebulous path and may be perceived by people "to do things."

Herbalists are another important health care resource in Trinidad. This group of healing specialists de-emphasizes the supernatural role in illness. Instead, they apply their knowledge of medical botany to treat bodily complaints. This form of traditional medicine is fast spreading its branches into the modern medical economy. Herbs are sold by middle-aged black males who may peddle their products on stalls erected on the sidewalk. They often sell leaves, bark, or roots in their raw form, and they sometimes dry, grind, mix, and bottle the herbs for convenience and "to keep the secret from getting out." Other forms are sold in packages of powder, tablets and even pills which often find their way on the shelves of drugstores. Herbalists sell medicine for the common cold, back pain, rheumatism, asthma, infertility and male

impotence. Through trial and error, they often devise effective means of dealing with new illnesses for which they have no models.

Priests, *maulavis* and *pandits* [Muslim and Hindu priests respectively] of the mainstream religious churches are less awe-inspiring than *obeahmen*. The *maulavi* functions as a spiritual healer who calls upon Allah to bring peace to the individual's mind, spirit and body, as well as the wider community. They rely on prayer, Koranic verses, and Arabic formulae in their medical practices. They practise fasting and other forms of abstinence in order to obtain divine assistance. Some of them become possessed by a *jinn* [spirit] through whose powers they heal. They make *tabeeges* [amulets with written Koranic scripts] which affected persons are given to wear (see also Moore 1995). They often wear a white tunic and skull cap, and grow a long beard, and they operate from their home or the mosque. They often diagnose the cause of a mental disorder as a spirit-attack which must be cured by exorcism.

Pandits [Hindu priests] usually treat minor complaints like the evil-eye by reciting curative *mantras* [sacred formulae] in a low voice at high speed. They are consulted mainly by Hindus to give an astrological reading and interpretation of life events. The severity or persistence of a disease may be linked to unfavorable cosmic influences or bad *karma* (law of cause and effect) for which palliative measures such as a *puja* (ceremonial prayer) would have to be done (see Kakar 1989). Parturient women consult *pandits* to determine whether there would be complications during the pregnancy, labor and childbirth. *Pandits* are also asked to state whether the day the child was born was "good or bad," to give a name to the child, and to set the date for first bath of the new mother. *Pandits* conduct healing by *jharuy-phukay* (stroking and blowing) (Ramnath 1982, Vertovec 1992). They also give

jhantars [amulets made of Hindi and Sanskrit writings in geometric designs] to be worn against evil forces

There are persons who are not considered mainstream priests but who perform certain healing rituals in their temples on Sundays. These healers--many of whom are women--go into trance or possession, perform animal sacrifices, act as spirit mediums, and subsequently offer direct consultation, exorcism, or hands-on-healing. They are usually of the Indian-based Kali-Mai sects (Vertovec 1992), and the Afro-based Shango/Orisha and Spiritual Baptists faiths (Houk 1995). They disclose information about the nature, cause and treatment of illnesses, and they treat patients for a variety of problems like menstrual pains, infertility, evil-eye, thrush, jaundice and unwanted pregnancies (Simpson 1970:54-69, Vertovec 1992:217). They often prescribe remedies such as herbal drinks, baths or fasting, and resort to supernatural cures which may take the form of performing placating rituals, anointing the sick, or reciting powerful prayers. Diviners also fall in this category of spiritual healers and, like *obeahmen*, are known as "seer-(wo)men." To divine the cause and cure of an illness, they look into the flame of a *deeya* [earthen lamp] or candle, or study magical seeds cast on the floor.

Many people in Trinidad visit folk specialists who give chiropractic-like massages for musculoskeletal pain. These specialists are mainly Indian men who are referred to locally as "the man who does massage." The traditional bonesetters treat sprains, fractures, dislocations, contusion wounds, injuries related to falls and automobile accidents and musculoskeletal pain. They treat patients by "cracking their joints," massage, prayer, and herbal applications (Naipaul 1957, see also Cooper 1993:5). Full-time practitioners work at home in a room specifically set aside for this

purpose. They have special "office hours and days" and, the five of them I visited, have an average of 15 patients per day. Like massaging, the knowledge of "cracking" is acquired from close family members (see also Hart 1978:83), but the present generation of adults is not interested in learning.[6]

Up to the early 1960s, midwives in Trinidad performed a variety of activities which included normalizing the position of the fetus in the womb, assisting with the delivery, cutting the umbilical cord, preparing herbal teas, and the washing of dirty linen. They attended to mothers for extended periods before and after the birth, and provided ritual and emotional care and dietary advice. They also treated bone dislocations and fractures, and administered to other ailments as well. Midwives found favor with parturient women because of a combination of factors which included cost, convenience, familiarity, perceived quality and duration of care. Their main duties were later monopolized by mainly male obstetricians who now operate in public and private hospitals (see also Burghart and Reissland 1989). Midwives acquired their knowledge mainly from older midwives who themselves had no formal training in obstetrics. As was/is the case in India (Mayo 1927), village midwives in the Trinidad Hindu community belonged to the lower caste who dealt with unclean and contaminated substances. Despite the truncated role of midwives--whose duties are now reduced to massaging--they remain an unofficial source of specialized perinatal health care for postnatal women convalescing at home (Klass 1964). The elderly midwives/masseuses of today, remain the last repositories of traditional knowledge on maternal and child health care (see also Cosminsky 1982). The urgency of the situation demands that these former-midwives be studied before they, and the knowledge they hold, disappear forever.

Literature Review

From a critical medical perspective, most of the literature on, or referring to, traditional medicine in the Caribbean remains descriptive, static, ahistorical and atheoretical (e.g. Niehoff and Niehoff 1960, Sobo 1993). Though such literature often provides rich ethnographic material on illness and health, it fails to examine individual and community beliefs and actions in light of the larger socio-political and economic context. Perhaps the only work which approximates this research is 'Creole and Doctor Medicine' by William Aho and Kimlan Minott (1977). The findings of the researchers disprove the hypothesis that rural mothers do more self-treatment than their urban counterparts and that they believe more in folk causes of illness. Alternatively, their data support the hypothesis that rural mothers use more folk/creole cures, and they also have more unfavorable attitudes toward 'doctor medicine,' including practitioners. Their study is similar to the current research not only because the research was done on beliefs and practices of mothers on selected infant illnesses in rural as well as urban Trinidad, but because it also investigates the attitude of low-income women toward modern, scientific medicine. Moreover, their research has stated implications for health education and delivery of health care services in other developing countries. On the question of change of beliefs and behavior, Aho and Minott write, quite appropriately, that "[a]ttempts to change the [biomedical] health care providers themselves may be a faster, cheaper, and more effective method" (p. 355). They add

> This research and similar, more refined studies, should provide a basis for practitioners to integrate their healing techniques with the belief systems of their present or potential patients . . . practitioners could cooperate with

> folk healers on their home ground, or permit them to have some privileges in a clinic or hospital (p 355)

But Aho and Minott's research falls short on many counts. They failed to conduct a cross-cultural analysis in a multi-racial, multi-ethnic society like Trinidad. Additionally, they ignored gender and class perspectives, and the explanatory models of biomedical practitioners are not fully articulated (cf Keck 1993, Kleinman *et al* 1978). Moreover, they do not also lift their gaze from their microscopic study of the hot-cold system of classification and the evil-eye ("maljo"), to examine the national and global political-economic contexts of health systems. Like other critical medical anthropologists (e.g Singer 1990), I intend to examine on-the-ground phenomena as well as the larger socio-economic and political forces.

Michel Laguerre's *Afro-Caribbean Folk Medicine* (1987) is perhaps the first and only published monograph that deals with traditional medicine in the Caribbean. In his "Preface" he (1987:vi) states quite appropriately that "[t]he study of the folk medical traditions of the black population in the Caribbean is in an embryonic state." He focuses exclusively on blacks, by which he means people of African descent, and does not even refer to the medical traditions of other ethnic groups in the Caribbean. While he should be credited for tracing the roots of Afro-Caribbean folk medicine in the ecological soil of the plantation system, he fails to locate them within the contemporary socio-economic and political context. Though he (1987:10) acknowledges that the objective behind cosmopolitan medical system is "monopolistic," and it "smacks of neo-colonialism," he does not carry his argument through to apply it to his mainly microlevel study of traditional medicine. He (1987:10-12) espouses materialist rhetoric in his "Introduction" by stating that the policies of biomedical institutions have been influenced by

the ideology and practice of North American medicine and will, therefore perpetuate inequality and injustice because traditional medicine has been confined to the "margins of society."

Laguerre (1987 10) adds that "[t]he relationship between cosmopolitan medicine and folk medicine must be seen as a microcosmic expression of the intermittent struggle between the hegemonic and popular classes." What a better way to dramatize this struggle than to draw comparisons, say, between the roles of traditional midwives who visit homes and modern upper-class male obstetricians who treat their clients in their clinics. Laguerre is often not consistent with the variables he "compares" in most of his chapters. Moreover, he fails to explain precisely how modern medicine has incorporated some elements of folk medicine. Certain fundamental questions are never even raised in his 1987 monograph, for example. What impact would SAPs, prescribed by the World Bank and IMF, have on the survival of folk medicine in the Caribbean? Neither does he offer any concrete suggestions on how the common masses can use black magic to take care of themselves, and others, without having to rely on "capitalistic white medicine."

In their report entitled *Socialization for Scarcity* (1981), Alvarez and Murray present a somewhat detailed description and analysis of food-related beliefs and behaviors in a rural community in Haiti. In one section of their report, they deal with the organization of postpartum confinement. They make comparisons of Haitian beliefs and behaviors with modern medical concepts, though not as often as one would have expected. The strength of their work lies in the explanations of their findings in the context of the deteriorating rural economy rather than in terms of peasant nutritional ignorance--which is the theory that they disprove. Though the authors rise

above treading the beaten path of describing rituals of proscriptions and prescriptions, they fail to take a full stride into the road that connects the rural culture to the political and social freeway of the wider society

In spite of the wealth of information on ethnicity (e.g. Yelvington 1993) and women in Trinidad (e.g. Mohammed and Shepherd 1991), we know nothing of the women who participate in the informal health care sector who protect and promote the health of others. Even in the local traditional medical system, men dominate as priests, shamans, bonesetters, and diviners and women are relegated to the more domestic caring roles as midwives and masseuses. In this study, I investigate the differences among various racial and ethnic groups of postnatal women on how they perceive, evaluate and react to comparable health situations. I also focus on informal health-care providers, particularly the newborns' grandmothers and folk masseuses and the way women are socialized to the primacy of the family care. It is logical, therefore, that women should be the focus of this research as they are perceived to be the keepers of the culture and the source of primary care in the family. At the same time, I move beyond the microlevel focus and analysis to locate the data in a critical medical theoretical context. By using this approach, I locate microlevel behaviors, beliefs and meaning systems within the encompassing political and economic structures (see Onoge 1975, Singer 1990).

Summary

SAPs, implemented by governments of developing countries, have resulted in alarming increases in health care costs for the majority of people. The urgency of the situation demands that governments examine other

sources of health care provision to alleviate the expense and inaccessibility of biomedical health care services. Traditional health care providers like masseuses, remain an informal and invisible group with untapped development potential. In this study I use the postpartum period as an illustration to describe and analyze the nature of traditional medicine in Trinidad, and its potential for integration in the biomedical system. I frame my study within a critical medical paradigm to argue that biomedicine rather than traditional medicine, is supported by a male-dominated social elite for political and economic ends.

Notes

[1] "Trinidad and Tobago" will hereafter be referred to as "Trinidad" for the sake of brevity. The research was conducted in Trinidad alone.

[2] Since 1980, total health expenditure as a percentage of government expenditure in Guyana has also been declining (Sagewan 1992:247).

[3] Singer and Borrero (1984:269) argue that the labeling of folk and traditional medicine is problematic. They state that folk medicine is viable not because it is a continuation of a familiar cultural heritage, but because it is an innovative system in constant development. Its practitioners are actively involved in reshaping its beliefs and techniques, incorporating new approaches and modifying out-moded ones (see Press 1978).

[4] Niehoff and Niehoff (1960:161 & 172) claim that *obeahmen* in Guyana, and those of Spanish descent in Trinidad, are considered to be the most potent.

[5] Hindu *obeahmen/ojahmen* are known to use the *Indar Jal*, a notorious occult source-book for manipulating supernatural powers.

[6] An association of college-trained licensed chiropractors has recently applied to the Ministry of Health to have the practice recognized as an integral and complimentary part of the nation's health services (Tang Lee 1997).

CHAPTER 2
BACKGROUND

Trinidad is a unitary state with a multi-racial, multi-religious population and many diverse cultures. Any study in the social sciences that does not take the country's socio-cultural diversity into consideration suffers from a severe limitation (see Chavin 1996). A gerontological study done on women and published by PAHO in 1989, for example, does not consider race and ethnic variables in its research design. There are very real differences in frequencies and percentages to be observed in the occurrence of physical and mental disorders when data are cross tabulated according to ethnic lines. Hospital admissions for attempted suicides in the country, for instance, show a preponderance of female patients, of whom Indian women, 15-29 years old, make up the greatest number (PAHO/WHO 1994:416). Without such analysis health planners and practitioners would be unable to design programs of intervention that would be socially and culturally relevant and effective.

The general health situation in Trinidad has improved significantly over the past three decades. The country has increased the level of life expectancy, reduced the rates of infant mortality, and diminished the incidence of communicable diseases. Childhood diseases preventable through immunization have either disappeared or have come to be seen as only a minor nuisance. On the other hand, the country's present epidemiological profile, dominated by heart disease, malignant neoplasms, diabetes mellitus, and cerebrovascular disease, closely resembles that of developed countries.

Additionally, new factors like an aging population, unemployment, and financial constraints, now combine to pose real threats to the relatively good health status enjoyed up to this time (TG 1996)

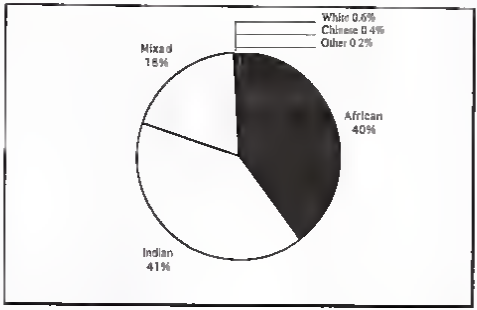
Country Profile

The Republic of Trinidad and Tobago comprises two tropical islands which are the most southern of the chain of Caribbean islands. Trinidad is located only 11 kilometers (7 miles) north-east of Venezuela which places it nearer mainland South America than any of the other Commonwealth Caribbean countries. Trinidad has an area of 4,828 square kilometers (1,864 sq miles) while nearby Tobago has an area of 300 square kilometers (116 sq miles). Trinidad was "discovered" by Columbus in 1498 and was ruled by Spain for varying periods until final capture by the British in 1797. Its population owes its origins to massive eighteenth- and nineteenth-century immigration of laborers who were brought mainly from Africa and India, as slaves and indentured servants, to work on the sugar cane plantations. In the early twentieth century, oil replaced sugar as the major export.

Trinidad is the larger and also the more highly developed of the two islands accounting for nearly 95 percent of the country's area and population, and by far the greater part of its national wealth (Banks *et al.* 1996:948). Approximately 44 percent of Trinidad's inhabitants live in the cities of Port-of-Spain and San Fernando, and in the county of St. George (PAHO/WHO 1989:3). In August 1976 the country became a republic with a constitution providing for a House of Representatives of 36 members and a Senate of 31 appointed by the president.

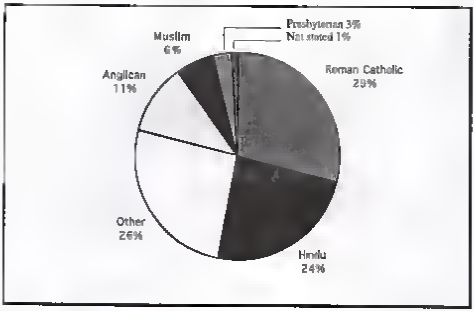
The population was estimated at 1 3 million in 1994 and the average annual population growth rate between 1981 and 1994 was 1.2 percent (EIU 1995/6) In 1995 the life expectancy at birth was 74 years for women and 69 years for men, and infant mortality was 18 per 1 000 (UN 1995 87) In 1993, the crude birth rate was 17.3 and crude death rate was 6.5 per 1,000 of the population (CSO 1993 3) During the same year, the population density was 24 6 per square kilometer (15.3 sq mile), the percentage of population under 15 years was 30 7, and persons 65 years and over comprised 6 3 percent of the population. According to 1990 population data (CSO 1993), Indians and Africans constitute two major racial groups of nearly equal size, being 40.3 percent and 39 6 percent respectively The rest of the population is divided into Mixed (18.4%), White (0 6%), Chinese (0 4%), and Other (0.2%) groups Roman Catholics form the majority (29 4%) of religious groups, followed by Hindus (23 8%), Anglicans (10.9%), Muslims (5 9%) and Presbyterians (3 7%), and Others (25 9%) (see Figures 2-1 & 2-2)

Trinidad is the most industrially developed country in the Caribbean. The country has an industrial base dominated by oil production and refining, sugar processing, and the newly built steel and petrochemical plants The country s natural gas resources came on-stream in the early 1980s and included ammonia, urea, and methanol (Meyerson *et al* 1987) In the mid-1980s, the production and processing of crude petroleum constituted nearly one-fourth of the GDP, 28 percent of government revenue and 71 percent of exports Following petroleum and natural gas the leading industries are manufacturing (chemicals, textiles, cement, processed food), agriculture (sugar cane, cocoa, fruits, vegetables), tourism and fishing Agriculture comprises only a small share of the GDP and employs about 10 percent of the total labor force



Source: CSO 1993

Figure 2-1 Ethnic groups in Trinidad



Source: CSO 1993

Figure 2-2 Religious groups in Trinidad

The fall in world oil prices in 1982 and again in mid-1990 contributed to a significant decline in the country's economic status and an increase in unemployment, malnutrition and poverty (Caribbean Economic Handbook 1985 145). Faced with rising debt-service payments, falling export earnings, and a widening budget deficit, a series of austerity measures were introduced in 1988 under the IMF Structural Adjustment Program. A survey of living conditions conducted in 1992 (MSD 1996) revealed that poverty level had increased from 1988 to 35.9 percent due to difficult national economic circumstances. The survey also revealed the incidence of stunting (4.1%), wasting (5.3%), and malnutrition (8.9%) of children under five years of age. It was also noted that large families, the unemployed, the elderly, and female-headed households were the groups that suffered poverty the most. The percentage of people living in poverty in 1993 was two percent for urban areas and 21 percent for rural areas. A comparison with Jamaica reveals that Jamaica has four percent for urban areas and 18 percent for rural areas (ILO 1995 106).

Government on the islands is based on the Westminister system. The Peoples National Movement (PNM), an Afro-based party with Dr Eric Williams as its leader, came to power in 1956. He led the country into independence in 1962. The PNM was the party in government which ruled for 34 years (1956-86 and 1991-95).[1] The Black Power struggle in 1970, mutiny in the army, and an attempted coup by elements of the military, came close to overthrowing the government.

In 1986 the National Alliance for Reconstruction (NAR) led by Mr ANR Robinson contested the elections and won a landslide victory against the PNM. The NAR was a coalition of opposition parties which included substantial numbers of Indians both at the leadership and membership levels.

In early 1988, Robinson, as the Afro-Trinidadian Prime Minister sacked four Indian members from his cabinet, including the foreign minister and deputy leader of the NAR, Basdeo Panday. The conflict raised the sensitive issue of racial divisions within the Trinidadian society because the expelled ministers drew much of their support from the Indian community. In 1989, the expelled ministers regrouped themselves under a new political party, and the United National Congress (UNC) was formed. A great embarrassment to the NAR administration was an attempted coup by members of a black Islamic militant sect, the *Jamaat-al-Muslimeen*, in 1990 in which 30 persons died and 700 were injured (Deosaran 1993:19). The November 1995 elections catapulted the UNC into power, and Basdeo Panday became the country's first Indian Prime Minister.

Ethnicity

A frequent topic of discourse on many Caribbean societies is the definition, nature, and extent of social and cultural pluralism (see Glazier 1985). Trinidad is a classic example of a country where significant differences in ethnic, racial, religious, class and gender differences can be found. Most authors (e.g. Brawer 1965) who emphasize "pluralism," "heterogeneity," "diversity," or "acculturation" as theoretical concepts agree that there are significant social and cultural differences between Indians and all other groups in the society. Africans consist of the majority (66%) of the non-Indian population in Trinidad. The other groups are Chinese, Portuguese, Syrian and persons of combined racial ancestry, the majority of whom are classified as "Dougla" (a mixtures of Indian and African) and 'Spanish' (an offsprings of an African and a non-Indian). Culturally, the mixed population

is more akin to Africans than to Indians, and it is usual for demographic and social-science researchers (e.g. Abdulah 1990) to group all non-Indians together. The history of the respective migrations to the country, as well as religious, cultural, economic, residential, occupational, and other factors, all contribute to observed differences among the ethnic groups. Each ethnic group maintains cultural cohesion and presents continuous resistance when its members try to assimilate cultural elements of what is perceived to belong to the "Other." Significant ethnic differences exist, but these differences intersect with variables of class and gender (Keur and Rubin 1960).

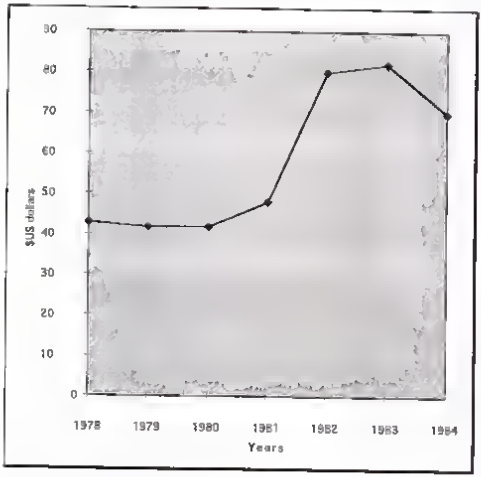
Until the 1960s, Indians were essentially rural agricultural residents and Africans were living and working in the towns (Brawer 1965). Rapid changes in urban migration and Westernization have taken place and the ethnic identity of Indians has become more complex. Lieber (1981:31-32) argues that the Indian in Trinidad becomes a cultural loser when he moves to an urban environment where conditions do not make it feasible or practical to sustain traditional behavioral patterns. Such individuals face pressure by the overwhelming Afro-Creole voices to modify their behavior or conform to a creolized version of a Trinidadian culture. He adds that Indian cultural intentions have been most fully realized in rural ethnically homogenous settings. What Lieber fails to realize is that the Indians who have left the countryside have not forgotten their roots/routes and they, in fact, revisit their natal homes to draw sustenance and to nourish their transplanted identities (see Ericksen 1992:174). Moreover, Indians relocate themselves in urban areas amongst fellow Indians which makes it practical for them to congregate and share common cultural activities. Since Indians in the towns are generally wealthier than those in the countrysides (ILO 1995:106), they are better disposed to have more material resources to express

their ethnic identities of which musical bands and singing performances are just two examples

Electoral politics in the island have always been divided sharply along ethnic lines. The results of the November 1995 general election were a watershed in the political history of the multi-ethnic state The results resulted in an abrupt transition in power from a predominately African regime to an Indian-led government after the former had held office for 34 years The change is having serious ramifications in the society and is manifesting itself in disguised political protest movements led by African leaders at almost every level of the society Africans are of the perception that the continuation of preferential access to resources both material and symbolic, is dependent on the preservation of a black party in power (Ryan 1988:2) Premdass (1996:1) argues that in a place where inter-ethnic suspicion and rivalry run deep and are articulated every day on the streets "the society stands nervously on the brink of an outbreak of ethnic and communal strife"

Formal Health Care Services

The economic crisis that began affecting Latin America and the Caribbean in the early 1980s is the longest and the deepest since the Great Depression. Prices of medicines and medical-surgical equipment increased due to domestic as well as foreign inflation. The Trinidad government's expenditure on health services in 1997 represented approximately 5 percent (US $1.4 million) of the national budget (Phillips 1997:9), compared to 11 percent in 1983 (PAHO/WHO 1989:3) Figure 2-3 presents data on public



Source: Mesa-Lago 1992.

Figure 2-3 Trinidad government's per capita expenditures in public health 1978-1984 (in $US dollars) Figures exclude social insurance

health expenditures per capita by the central government (excluding social insurance) of Trinidad for 1970-1984 In Trinidad, expenditures peaked in 1983 and then declined in 1984 (Mesa-Lago 1992:44) According to the 1994 World Labour Report (ILO 1994), Trinidad is identified as one of the many countries in the Third World where actual health care expenditures to GDP were declining or at best stagnated, when economic growth was itself slow [2]

In Trinidad, hospitals constitute a system which provides secondary, tertiary and specialized services The two general hospitals provide mainly secondary and tertiary care, the three county hospitals offer secondary care, and the four district hospitals give primary health care. The district hospitals are equipped to handle normal maternity cases, minor ailments and other infirmities not requiring the use of specialized diagnostic or therapeutic facilities. These hospitals are part of the district services and support the services provided at the health centers The network of 102 health centers, strategically located throughout the country, serves as centers for the administration of basic public health services. They have been established at the subdistrict level, but they are underutilized due mainly to a lack of equipment, well-trained personnel and adequate funds The quantity and quality of the services have been affected by leaky roofs, limited space, shortage of medications, and the lack, or non-functioning, of equipment (Richards and Sankar 1995) There are seven Delivery Units which provide adequate delivery care for simple uncomplicated maternity cases With its emphasis on high technology and users fees, Mt Hope Hospital clearly did not respond to WHO's resounding call in 1978 to concentrate on primary care (see Dean 1991)

There are over 15 private health institutions with 292 beds (PAHO/WHO 1989:3) that include private nursing homes and hospitals

located in north and south Trinidad They were observed to be "doing much more business these days" with the fast turnover of patients because of the declining state of services at the nation's two general hospitals (Lopez 1990 1). During her research in Trinidad in 1990 in the gynaecologic and obstetric wards at four public hospitals, including Mt Hope, Phillips (1996 1425) made an important finding She discovered that many patients claimed that when they visited doctors in their private offices, the attitude of the doctors was better, even by the same doctors Private institutions, therefore, capitalize on the poor quality of health care offered in the free public hospitals that are often in a state of crisis.

In 1993 it was estimated that there were 1,051 physicians, 2,266 nurses and midwives, 1,256 nursing assistants 166 nursing aides 60 hospitals and nursing homes, and 4,216 beds in private and public health institutions (CSO 1993.2). In 1989 the local newspapers (TG 1989 8) reported that the Port-of-Spain hospital did not have cotton wool. Nurses had to use toilet paper soaked in alcohol to administer to newborn babies These shortages were the cause of much public anxiety In 1995 (Richards and Sankar 1995), it was reported that there were shortages of medical supplies and equipment necessary for proper care of patients in hospitals throughout the country Again in April 1997 (Nanton 1997, Rostant 1997), it was reported that there was a shortage of cotton wool, blood culture bottles, bedsheets electric bulbs, and surgical staff It is theorized (see READ 1989 12) by health administrators that the main reason for these recurring problems is the scarcity of foreign exchange to pay for imported medical commodities.

The Regional Approach to Health

After decades of dissatisfaction with the poor quality of care available at public health institutions, Trinidad's Ministry of Health (MOH) decided to design and implement a health care reform program (MOH 1995). The aim of the program--which is still in progress--is to fundamentally change the way in which health services are financed and delivered in the country. The reform is also in keeping with the policies of the structural adjustment program, implemented since 1987, in which social services which were once thought of as "public" were to become privatized (Phillips 1994:143). While other Caribbean countries like Jamaica and Saint Lucia have pursued partial reform through the introduction of user fees and the development of insurance schemes, Trinidad has proposed the most radical changes in its health sector. The reform, using non-reimbursable funding from the Inter-American Development Bank (IDB), is based on feasibility studies done on decentralization, one of which was the commissioning of the Medical Sciences Complex at Mt. Hope (MOH 1995).[3]

The structure of the MOH began changing in 1993 into a form of decentralized administration ("regionalization") with emphasis on primary health care (Phillips 1994:143). The MOH is divided into five operationally autonomous corporate entities called the Regional Health Authorities (RHAs). Each entity is headed by a Board of Directors with responsibility for the provision of a continuum of health services within a defined geographical area. Broad policy guidelines are set by the MOH which is involved in the setting of standards and the monitoring of the services delivered by the RHAs. The MOH also determines the policy framework within which the RHAs carry out their programs and service delivery. The

MOH also decides national health priorities and establishes goals and targets to be met by the RHAs (MOH 1995) It is the ultimate intention that the MOH will perform an administrative and monitoring function instead of the executive role which it is still, to some extent, performing (Phillips 1994)

The reform does not only deal with a new administrative structure but also with the re-orientation of the health services. The main thrust of the RHAs is the emphasis on primary health care that would be delivered to the public in an affordable and accessible manner It is envisaged that improvements in the primary care system will redound to the benefit of the overall system through reduced demands on the secondary and tertiary facilities that are at present consuming a large share of the health care budget. It is expected that if such type of care were available at the community level, there would be no need for patients to travel long distances to an already over burdened secondary health facility The new focus on primary care will require a shift in resources from the secondary to the primary care sector with better equipped health centers and hospitals with improved facilities as well as emphasis on ambulatory care and a national ambulance service staffed by trained paramedics (MOH 1995)

An additional aspect of the health care reform is the introduction of a National Health Insurance System with the government paying for the medically indigent (MOH 1995) [4] Hospital care at the Mt. Hope Medical Complex is already being provided on a fee for service basis In situations where patients are unable to pay, financial support is provided through a Patient Trust Fund, or alternatively, the MOH would reimburse Mt Hope for services provided to patients who, under normal conditions, would have sought treatment from the public institutions (Mt. Hope Hospital 1992) It is interesting to note that the new Mission Statement of the MOH enunciates

that it is now in the "business of promoting health to the people of Trinidad Phillips (1994 144) states quite clearly that, under the reform, other public health institutions are to function on a profit-making basis similar to that of Mount Hope hospital' in their delivery of services

Despite the effort to establish new, more efficient, and reliable service to patients, the reform package is still inadequate to satisfy the needs of the ethnically-diverse population The government's view of health care is based solely on a biomedical model that, in many ways, is different from the peoples perception of health and healing, especially in the diagnosis and treatment of certain culture-specific illnesses The architects of the reform program failed to recognize that an informal health care sector exists in the country that has a tradition which spans many generations. There are already signs of uneasiness among local health care providers about the high drug rate prescribed by physicians

> Patients are seen as targets and we aim drugs as darts at them No drugs does not mean no treatment Relying solely on drugs make us mere technicians practicing almost veterinary medicine and *refusing to see the full human dimension of our patients* No drugs also mean that we are allowing an illness to take its natural course or that we are allowing the body to heal itself (Sieunarine 1991 11, emphasis added)

The architects of the reform neither acknowledge the role of folk/traditional healers in the community, nor do they envisage a way in which some aspects of the folk/traditional medical system can be integrated into the primary health care program. In other words, the reform does not seek to tap the local resources of the people at the community level to create an holistic approach in which patients can treat others and themselves for at least a few ailments (Alexander 1996 20)

The Research Site

The research on traditional health beliefs and practices of postnatal women was done in Trinidad during three seasons in the Summers (mid-May to mid-August) of 1994 and 1995 and from mid-May to mid-December in 1996 I interviewed 64 postnatal women and 45 traditional health care providers, especially masseuses I also interviewed 45 biomedical practitioners including physicians (n=30) as well as nurses (n=15) Altogether, I spent 13 months in the field.

The site of my research on postnatal patients and their healthcare providers was the county of St. George Central which spans many urban districts located in north Trinidad between the St Joseph river and the Laventille Flyover The area is 133 square kilometers (86 sq miles) with a population of 150,000 people The annual number of births is 4,000 children. The health centers located in the area are Laventille, Morvant, Barataria, Aranguez, San Juan, El Socorro, St Jospeh, Maracas Valley and Santa Cruz The Mt Hope Women's Hospital and the adjacent Eric Williams Medical Sciences Complex are located in this county There are two private hospitals and many clinics owned by private practitioners St. George Central has an ethnically heterogeneous urban and sub-urban population living in houses ranging from shacks to bungalows.

Mt. Hope Women a Hospital was selected for this study for three reasons First, it was the only hospital that granted me permission to access information and, at a later request, to introduce myself to female patients in the ward (see Appendix 1) The hospital s Chief of Staff, Dr Syam Roopnarinesingh, is a researcher and writer himself, and holds the view that findings on the institution would be beneficial to the improvement of the

quality of care, and the health care system as a whole. Requests to conduct research at other public and private hospitals were unsuccessful on the grounds of patients confidentiality and right to privacy. Second, Mt. Hope Women's Hospital is one of the largest hospitals of its kind in the country with a capacity of 110 beds and a neonatal unit of 36 cots. Third, it was convenient and economical for me to travel to the hospital from my house in San Juan by mini-bus in a travel-time of half an hour. The hospital catered mainly for patients who lived in the surrounding districts, but some parturient women gave misleading addresses to the registration clerk in an effort to enter what was considered to be a better institution. The hospital is equipped with a medical records department and library which were of immense use to me in securing information about the hospital's administration and its patients.

Mt. Hope Women's Hospital was built in 1983 and became a teaching-hospital affiliated to the University of the West Indies. The postnatal ward is on the second floor of the brick building (Figure 2-4). It holds 44 beds—five in each room and two in single-bed rooms for women with infectious diseases. High-risk patients, like those who had C-sections, high blood pressure, or excessive blood loss, are placed in rooms 105 or 107. These rooms are located opposite the nurses' station so that the nurses can be constantly vigilant ('keeping an eye") about the patients condition. Each room has its own toilet and bathroom. These, however, are too small to accommodate a patient on a wheelchair with an assistant. The rooms are not air-conditioned, and the wooden windows are always kept open for fresh air.

The nurses station is located in the middle, and on one side, of the ward. The station's position does not allow nurses to control the entry of

Figure 2-4 Mt. Hope Women's Hospital has 110 beds and a neonatal unit of 36 cots.

people who may want to see patients in the ward outside of the stipulated visiting hours. The entry of males is particularly distressing for parturient women who may be in various degrees of undress on their beds. The nurses said that the ward was designed without any consultation with them. There is the Sister's office in which the Ward Sisters seldom stay because they have to assist other nurses on the "floor" because of a shortage of staff. The two Ward Sisters have the unpaid responsibility of supervising all nursing staff which, one Ward Sister said, is a duty that should be done by a paid Supervisor. The Matron's office is located on the ground floor. She visits the nurses from time to time, usually in relation to her paperwork.

A nursery is also located in the postnatal ward adjacent to the nurses station. Newborns are taken to this room to stay and be fed if their mothers are unable to take care of them.[5] Newborns are fed by the nurses with a bottle (instead of a cup and spoon) after which they are monitored to determine whether the gastrointestinal tract is in good condition. Other infants are "roomed-in" in a cot beside the mother's bed with the intention of establishing a maternal bond. There is a lunch room for nurses on the side of the nurses station. There are also four small rooms: the sluice room where bloody and stained linen are placed, a treatment room for the storage of medical supplies, and a pantry where food and drinks are distributed, and a storeroom. There is a ward clerk who is present during the day for five days a week. The ward is usually quiet except for the prattle of the predominantly African nurses, and the non-Indian music emanating from a transistor radio.

Mt. Hope Women's Hospital is located in a large urban area serving districts along the densely populated East West corridor not more than five minutes walk from the Eastern Main Road and the Priority Bus Route, both of which run parallel to each other. San Juan is the bustling center of

commercial activity, at the junction of which are a bus terminal, a taxi stand, a post office, a fire station, a mainly vegetable market, shops, stalls, fast-food outlets, commercial banks, gambling booths, pharmacies and doctors offices. Within a stones throw from the intersection is a shopping mall a library, schools a mosque, mandir, and a church. Unlike most of agricultural Trinidad which grows sugarcane residential St George Central has cocoa plantations and vegetable fields on the outskirts of the county In an effort to meet some of the caregivers and masseuses who attended to my postnatal informants, I had to travel to areas beyond St George Central Some of the new mothers had returned to their natal homes outside the county to rest and be treated during the puerperium

Summary

Trinidad is a classic example of a society where significant differences in ethnic, racial, religious, class, and gender differences exist Is is also one of the countries in the Third World where actual public health care expenditures to GDP are declining. The government has decided to design and implement a health care reform program in which free public health services would be discontinued I argue that the reform package would still be inadequate to satisfy the needs of the ethnically diverse population because the official view of health care is based solely on a biomedical model The architects of the reform program neither acknowledge the role of folk/traditional healers in the community, nor do they envisage a way in which some aspects of the folk/traditional medical system can be integrated into the primary health care program.

Notes

[1] During the long reign of the PNM, there were political patrimony, racial discrimination, mismanagement, corruption, and extensive bureaucracy (Premdass 1993).

[2] Presently, Government spends more than 100 million U.S. dollars in the provision of health services, while the private sector spends about one million dollars (Homer 1997)

[3] The Mt Hope Medical Sciences Complex houses the first hospital that was administered by a board responsible to the Minister of Health Primary (walk-in) secondary, and tertiary health care--both inpatient and ambulatory--are provided on a limited scale The hospital is vested in the board, which has to levy charges in order to balance its budget Even though the Ministry provides a large subvention, it also pays the fees of patients referred from government institutions

[4] Since 1988 there has been an increase in the number of people seeking free treatment at the public health institutions, and these numbers are likely to increase even further as more households face reduced incomes (READ 1989 12).

[5] Inability to breastfeed may be the result of sedation of the newly delivered mother, or she may have to wait on the ground floor to be sutured by a doctor after an episiotomy

CHAPTER 3
THEORY AND METHODOLOGY

Any investigator should be aware of his own biases, cultural predilections and theoretical perspectives so as to minimize any interference in receiving and interpreting information. Anthropologists are trained to get an insider's perspective and not to use their own cultural norms to guide interpretations. As an anthropologist from the country/culture I was studying, I saw the world from the point of view of some of my informants, but I had to ensure that I was getting the full array of perspectives and not imposing my own or making my own assumptions (see Nash 1981:409). I was interested in trying to understand and analyze their (and sometimes my own) belief systems and world views, and in how they constructed these in real-life situations. Some anthropologists (e.g. Koss-Chioino 1992) have used the opportunity of being an "insider" to achieve a kind of integration of the emic and etic perspectives that has made their study unique.

Trinidad is an ethnically heterogeneous society and there are ethnocentric secrets that are not revealed to people outside of certain groups (see Mitchell 1991). It was my challenge to collect specific information, discover the hidden secrets of my informants, and to locate that information within a folk or biomedical model. My subscription to a critical medical theory (Singer 1989) made it possible for me to rise above the restricting focus and analysis of a microlevel circumscription of the community I was studying, to a wider economic and political realm which overarch all Third World countries. The failure to transcend local personal interactions and

examine impacting global power structures has been a significant weakness of mainstream ethnomedical and community health studies.

Overview of Theories

Medical anthropology is the study of health-related phenomena. These range from the individual-level biological studies, such as those examining cultural differences on hypertension and malnutrition, to macro-level studies of health care systems and their political and economic contexts (Chrisman and Johnson 1996). The field embraces many perspectives and foci of concern.

Anthropologists who study disease and health-related behavior in an ecological setting belong to the school of ecological medical anthropology. Armelagos *et al* (1980) argue that the division of the environment into inorganic, organic and cultural components has been found to be useful for a holistic understanding of health and disease phenomena. From the ecological perspective, disease ecology focuses on the interaction between two organisms: the pathogen and the host. Adherents of this paradigm have been criticized for refusing to analyze critical relational factors such as ownership of the means of production, export of capital, extraction of profit, and racial and sexual oppression (Singer 1989).

The biological or biocultural school is characterized by research on questions of human biology and medical ecology as they examine relationships among biological, environmental, and cultural factors (McElroy 1990). Central to biocultural studies is the interest in the body--its biological nature, how it has been shaped by evolution, and by environmental stresses. Research of this kind attempts to measure, describe and interpret constraining factors by using biological indicators such as anthropometric indices, blood pressure apparatus, etc. Ultimately, however, the goal of such research is to

illustrate how people in different environments, cultural groups and societies respond to illness and come to confront the constraints on their health and the quality of their lives (Wiley 1992) One criticism of this approach is that its proponents have aligned themselves so closely to a Western biomedical model of health and disease that they do not question how political and economic factors may determine a community's health-behavior (Singer 1989)

Medical anthropologists also study biomedicine itself, exploring the ways in which it is socially, culturally, and historically constructed The proponents of the clinical and clinically applied anthropological theoretical approach have been criticized because of the clinical settings in which they work, and the role they unwittingly perform in sustaining the dominant political and economic system (Rhodes 1990) They focus on using the concepts of anthropology to explain and suggest changes for the health care system, and patients within the system. Some anthropologists take care of patients, but this activity occurs primarily because they also have clinical training as a physician, nurse or counselor like Toni Tripp-Reimer and Molly Dougherty Clinical applied anthropology is seen as the application of anthropological data, research methods, and theory to clinical matters (Chrisman and Johnson 1996)

Medical anthropological studies have brought into focus global structures and power relations, as well as hegemonic ideologies that transcend geographic boundaries. The devotees of political economy in medical anthropology (PEMA) transcend the conventional ethnographic "emic" accounts and focus on global power relations that touch the lives of their village informants (Soheir 1990) They use this theory to explain the present world holistically in terms of the growth of the world-system, the

penetrating effects of capitalism, and the determinant role of class, sex, and race on social behavior (Singer 1989) One criticism of PEMA is that its followers depersonalize their informants "by focusing on the analysis of social systems and *things*, and neglecting the particular, the existential, the subjective content of illness, suffering, and healing as *lived* events and experiences" (Scheper-Hughes and Lock 1986:137)

The proponents of critical medical anthropology define it in terms of a concern with the macro-level political and economic forces that shape medicine and its role in social and cultural life They study the relationships among social inequality, inadequate medical care, and ill health, and recognize the importance of class, racial, and sexual differences Critical medical anthropologists, broadly speaking, operate from a materialist theoretical orientation (Morgan 1990) This approach has been used synonymously with PEMA (Morsy 1990). It differs from PEMA in its ability to show interconnections between micro- and macrolevels of social interaction "Not all critical anthropologists adhere to orthodox Marxism Some prefer a phenomenological and humanistic, yet politically informed, approach to sickness and healing" (Morgan 1990:945) Critical anthropologists are overtly driven by political motivation and they perceive science itself to be suspect, being one arm of an exploitative Western capitalistic apparatus. One major criticism of this perspective is that it has much to say in scholarly pronouncements, but little to do in terms in redressing the contradictions inherent in capitalistic health care

A Critical Medical Approach

I locate my ethnographic work in a political-economic context as has been done by many critical medical anthropologists (e.g. Singer 1990b). I dwell on, and move from, close encounters with postnatal women and their interaction with informal health care providers to the larger encompassing holism of the political-economic structure. The theoretical orientation of anthropologists who adhere to other schools is limited, because they remain too rooted in the direct interaction with their participants and cannot rise above the *in situ* setting (Wolf 1982). Critical medical anthropologists are concerned with synthesizing the macrolevel understandings of political-economy with the micro-level sensitivity and awareness of conventional anthropology. They focus on socially constructed units of individuals that have an economic and cultural commonality, such as classes, institutions, or nation-states, but stress the hierarchical nature of group differentiation. My focus is on health-related behavioral differences based on race and ethnicity, but I extend my study to gender distinctions as well.

Many social scientists restrict their focus to small microscopic 'primary' group settings, and make little or no attempt to encompass the totality of the larger society's social, economic and political structure (see Onoge 1975). "One of the hazards in ethnographic work is that the field experience cultivates the emic view of one's informants that treats the overarching dominant structure as irrelevant" (Nash 1981:409). In my research, I examine the variables of race- ethnicity, class and gender as part of a totality of interconnected units. I locate micro-structures such as the healer-patient interaction within more macro-sociopolitical and economic structures such as class relations, power, social control, and ideology. The macrolevel

forces and structures are not external to beliefs, behaviors and relations Indeed, critical research unveils how micro-level behavior is a reproduction and reinforcement of broader structural patterns in society Consequently, research must be directed at clarifying the manner form and degree to which macro-processes are manifested at the micro-level

Western medicine as is promoted in developing countries cannot be studied apart from its social and political context of power relations. I examine how Western medicine is penetrating, subordinating and destroying even the beneficial aspects of traditional medicine through the promotion of a capitalistic model of biomedicine The domination of Western medicine--variously known as bio-, scientific, allopathic, or cosmopolitan medicine--can be described as bourgeois medicine because of the economic motive behind this type of health care system The term "capitalistic medicine" identifies a key feature of this health care system because of its role as a mechanism for social control, capital accumulation, systemic legitimization, and reproduction of class and gender inequalities (Lazarus 1988 Singer 1990b) By subscribing to this theory, I attempt to bridge the macro-Marxist/micro-phenomenologic divide to give voice to low income mothers, unlettered grandmothers and aging women healers

I also discuss the similarities and differences of explanations between traditional and biomedical systems with respect to postnatal care in Trinidad Areas of discussion between the two systems include etiological beliefs diagnosis, treatment repertoires the practitioner-patient relationship, and perceptions of the body Biomedical practitioners deny the existence of a number of illnesses experienced and recognized by lactating women who are their patients For etiological explanations of illnesses that both categories recognize, doctors fix culpability solely and squarely on elements of the

physical world Postnatal women and their traditional health care providers confer a coherent system of explanation that extends to other variables like evil elements and assaults of the environment (cold, dew, moon etc) Traditional causal explanations may also include biomedical understanding of the workings of the organic body Compared to biomedicine, traditional medicine addresses a wider range of issues people believe are directly related to health such as astronomy and the spirit world

Some ethnographers assert that the result of most studies on folk theories of disease show that they bear a complex relationship to medical theories of disease, and that some are certainly influenced by professional medical concepts. According to Kleinman *et al.* (1978:256), explanatory models of illness contain "explanations of any or all of the five issues: ethology, onset of symptoms, pathophysiology, course of sickness (including severity and type of sick role), and treatment."[2] Professional explanatory models fulfill the same goals, only they do so by the application of scientific concepts and knowledge acquisition and are used and communicated to the rest of society by modern professionals My objective behind comparing patient, healer and physician's explanatory models is to illustrate the differences between social class, religious affiliation, racial identity, gender orientation, generational variance, and educational levels (see Kleinman *et al* 1978).

Preparation for Fieldwork

I had to obtain official permission from administrative officers of the Ministry of Health in order to gain access to information and people in the health centers and hospitals. Although I had mailed letters of request four

months before going to Trinidad, it was not until I appeared in person at the appropriate offices that my request was considered. After several days of bureaucratic hurdles, I met Dr. Pooran Ramlal and later Dr. Elizabeth Foon King, Principal Medical Officers at the Ministry of Health, who granted me permission to visit the health centers in the medical county of St. George Central. Dr. Ramlal spent an average of two hours on five separate days discussing my research project with me from the perspective of a physician. He examined my proposal and interview schedules and offered valuable advice on sample size, types of healers I should interview, biomedical definitions of folk concepts of illnesses, phrasing of questions, and possible problems I was likely to encounter in the field because of my race and religion.

The Medical Chief of Staff at Mt. Hope Women's Hospital, Professor Syam Roopnarinesingh, recognized me as a writer as soon as I entered his office during my first appointment with him ("Do I know you from somewhere? Are you the writer of a book?") Being an author himself (Roopnarinesingh 1983), we instantly established a bond through our common preoccupation with research and publication. After consultation with the Matron and the Medical Records Officer, he gave me permission to visit the patients in the postnatal wards in order to introduce myself to them (see Appendix A). During the initial contact, I introduced myself to them, explained the nature of my project and asked for their voluntary participation in the study. If they agreed, an appointment was made for a follow-up interview at their homes after a six-week period. This introduction was critical in enabling potential female informants to easily recognize me when I later visited their homes. The final season of field research was done at a time when there was a high number of con-men prowling the streets to commit

crimes as serious as murder[2] Participation in, and observation of both routine and special events in the community also provided rich ethnographic information

I used multiple research methods to collect both primary and secondary data The final interview schedules I used were based on data collected through informal conversations (Mahabir 1988, 1992) pilot studies, participant observation, and information culled from relevant social science texts (e g Randall-David 1985), and popular literature (e g Naipaul 1953) Revisions were done to ensure that the questions were clear, non-leading, relevant, and socio-culturally appropriate. I began with simple socio-economic inquiries of a non-intrusive nature and then moved into more personal and sensitive areas Throughout the interaction, I tried to make my informants feel relaxed and open by allowing them to take control of the topic at hand, and by being conversational The administration of the schedule generated quantifiable data, which not only supplemented but also verified and challenged various aspects of the qualitative data

I also made use of secondary source materials such as informational handouts, brochures, posters, local newspapers, periodicals, official documents and census reports Through the examination of 210 medical reports, I elicited information on basic personal and socio-economic data like the patients name and address, present age, age at birth of first child, religion, marital status, occupation, number of children, relevant data on the Infant s birth and condition, date the patient was due for discharge, and data on the child s father (see Appendices A and B) For three months during randomly selected days of the week, I consulted the hospital record of each patient before making initial contact with them in their rooms At their homes, I inquired

about their educational attainment which was an important variable not included in the hospital document

I chose to conduct my fieldwork on the postnatal patients who had delivered at the Mt. Hope Women's Hospital because the site was accessible to me. The hospital also has one of the largest postnatal wards in the country with a complement of 44 beds, a monthly average of 1364 bed days, 342 deliveries, 504 patient days, 42 percent occupancy rates and a turnover rate of 8 patients.[3] The number of patients was large and ethnically-diverse enough for me to randomly select a sampling frame of 210 women resident in the county of St. George Central. The hospital was built to service the adjacent districts which consist of urbanized, formally educated, and more Creolized people. These amorphous types of communities have been largely ignored by visiting foreign anthropologists (e.g. Klass 1988, Simpson 1962). My surveyed (n=336) and focused (n=210) samples approximate the ethnic composition of the national population as a whole in terms of race and religion. My primary/key informants consisted of a total of 64 new mothers whose neonates were just over six weeks old. Thirty-seven grandmothers were consulted jointly with their daughters or daughters-in-law or separately. Six postnatal women, whose infants had died during the perinatal period, were also interviewed.

My method of locating masseuses was through references made by postnatal women, and through community networks (see also Trotter 1991). I found more of them living in rural areas where they formed a fairly vital segment of the traditional medical system. As I became more involved in the research, my informants referred me to other suitable masseuses in the community--thus forming a snowball sample. The snowball method has been reported to be extremely useful in recruiting members of hard-to-reach

populations (Bernard 1988) Arrangements to interview 30 medical doctors and 15 nurses on their views of folk healers and traditional medicine were made by telephone and personal contacts during their free office hours My concern in this domain was to investigate similarities and differences in the medical models of the two systems I conducted unstructured interviews with other traditional health practitioners such as bone-setters and herbalists as well as priests of the Orisha, Hindu, Muslim and Christian denominations

I dressed formally in long-sleeved shirt, trousers and shoes and carried a leatherette bag containing my camera, notebook interview schedule, mini-cassette recorder and umbrella It was necessary for me to appear as a professional, lest my informants took me lightly I was told many times that I appeared as a Christian proselytizing evangelist. This appearance worked to my advantage because it was unlikely that criminals would pick upon a Bible-toting missionary I commuted regularly from my house in San Juan to Mt Hope Women's Hospital, doctors private offices and informants homes. My research took me to a variety of houses. Some were painted tall brick houses complete with all utilities built on the sides of paved roads Others were wooden shacks, without electricity and pipe-borne water, squatting on state lands that had to be accessed by walking through bushy tracks and stepping over stones laid across a river I got directions to houses ranging from descriptions. "You go see two palm trees in the yard" to instructions. 'Ask the taxi-driver to drop you by Pitt's shop in Luengo Village And I live in the next house'! I selected a high-school educated Hindu/Indian woman as a research assistant to accompany me when I went to interview masseuses I allowed her to perform six trial interviews in the field under my supervision before I allowed her to go on her own.

In the Field

I did not have to present any kind of legitimizing credentials to my postnatal informants when I appeared at their doorsteps. I had already introduced myself to them a few weeks at the Mt Hope Women's Hospital. I always called those who had access to a telephone to arrange a convenient time and day for the interview. My masseuse informants did not require any identification because I was always in the company either of my female research assistant or of my wife. Moreover, once I mentioned the name of the person who had referred me to them, I was accepted without suspicion. In introducing myself to biomedical practitioners outside of the Mt. Hope hospital setting, I initiated conversation by placing my Anthropology Department's letter of introduction on their desk, and assuring them that any information shared with me would not be used against them individually.

I always initiated an interview with my female informants with a disclosure about my present social status as a married man with two children. This protocol was necessary because I was a man interviewing women--some of whom were about my age--about sensitive issues related to childbirth and child care. I emphasized to them that, in the event that I publish my research, I would change their names and other identifying personal details. My informants asked me the usual questions: Why did I want this information? What was I going to do with the collected data? Was I getting paid for doing the research? They also asked questions about the nature of a caput, the virulence of a head rash, the appearance of a birth mark, and the safety of a local medicinal herb. On medical matters, I reminded them--most likely to their disappointment--that I was not in a position to given an opinion and advised them to see a nurse or physician. In cases which required general

medical data (like the average weight of a premature baby) I offered them figures or promised to call them at a later date to provide the information.

There was little privacy on the wards when I was introducing myself to the patients on the wards. The five or six beds were close, and sometimes the women would sit together to chat and/or breastfeed their babies. When "the child father" or husband was at home, he made himself present and dominated in answering questions which were directed to the woman. In an effort to avoid this interference, I tried to visit the homes of postnatal women when the men were absent and children were at school. Group interviews with other women, especially the newborn's grandmothers, were lively and informative. Subsequent interviews with the same informant were done to elaborate on particular points of interest, or to seek confirmation or refutation of information already given.

All the interviews with postnatal women and masseuses were conducted during the day. To attempt to visit a stranger in the night would have been inconvenient for the women, and absurd in a crime-ridden society. After dark, people become suspicious of strangers, and it was generally a time when yard gates were padlocked and fierce watch dogs were set loose while the family settled behind steel-barricaded doors and windows. Most of the interviews with my female informants were conducted in the afternoon when they were finished doing or overseeing household chores like cooking, washing, cleaning, and serving infants and husbands. At almost all the homes, I found that at noon the women were watching soap-operas like "The Young and the Restless". The interviews generally took place on the porch ("gallery") after the soap opera had ended. Some were done in the "living/dining room" and a few were done in the bedroom in the presence of

Figure 3-1 Interview with a 73-year-old masseuse

the child's grandmothers. All the interviews were recorded on a mini-cassette recorder after I had secured oral permission, and I had assured them that no-one, except myself, would listen to the tapes (see Figure 3-1). The informants were told that they could withdraw from the study at any time or refuse to answer any or all of the interview questions. The elderly masseuses were apologetic about their use of Trinidad English ("Don't laugh at they way I does talk you know") and were amused to hear their voices when re-played.

The interviews lasted for an average of three-quarters of an hour and were sometimes interrupted by children talking, screaming, play-fighting, and running around the house, and the mother shouting at them to "behave." Toddlers in the house would rummage through my carrying bag. They would be delighted to excavate coloring books and crayons I carried with me to keep them occupied. In most of the recordings with new mothers, the gurgling of the newborns can be heard as their mothers breast- or bottle-fed them during the interview. There were other sound interferences emanating from household or neighborhood activities like the sound of a radio, loud group conversations, construction drilling, pounding, barking dogs, and the twilight utterances of crickets and frogs. In houses built near the roadsides, the sound of heavy vehicles climbing up the hills was particularly annoying. In only a few instances, I arrived in the middle of a family quarrel which my presence quickly dissipated. In the rural areas especially, curious neighbors made brief visits to express concerns about their own problems of water storage, food collection, house cleaning, garbage disposal, and yard weeding.

I must say something about the possible influences of my gender on the conduct of my field research among both old and young women (see also Gurney 1991).[4] My wife or my female research assistant often accompanied me when I went out to interview masseuses at their homes. A female

presence helped considerably in averting suspicion that I might be one of the many con men, thief or rapist prowling the neighborhood at a time when most men were at work. The issue of being a male field-researcher among female informants is a problem in some ways but one which could be resolved (see du Toit 1990, Jenkins 1984). There were only a few times when I was made aware of my male identity. In one instance, an Indian woman on the hospital ward informed me that her jealous husband would be angry if he learnt that I was at his house with his wife when he was out. An extra effort had to be made in getting Indian Muslim women to cooperate in the study. As expected, I did not even entertain the idea of witnessing the sixth or ninth day herbal bath of the new mother. My informant, the child's grandmother, the masseuse, my wife, and my female research assistant adequately filled in the descriptions. Generally, I did not feel my sex to be a major disadvantage.

I tried to be as professional in the conduct of my duties as was possible. It was only when I felt that rapport was established, and my female informants were comfortable with my presence in their own home setting, that I asked about the sensitive question of abortion. The older women would recognize me as a grown man who had a wife and children, and with whom they could talk about parts of the female anatomy by using local idiomatic codes. At the postnatal ward where I spent three months, I had picked up acceptable ways of saying things. For example, in asking if a woman had sustained an episiotomy, the nurses asked them if they had gotten 'any stitches down below" while directing their gaze to the vaginal area. I used these same expressions in the field with great success. On more than one occasion, my older female informants drew me away from my female research assistant, and her eavesdropping husband and daughter, to inform me of a sexual posture that a man could adopt to impregnate a woman.

perceived to be infertile When men, other than the child's father were present at home they stationed themselves as gatekeepers, sitting in the porch pretending to be reading the newspapers, but keeping a vigilant eye on my presence in case I might do something other than my stated intentions

On Being a Native Anthropologist

Much debate (see, e g Jenkins 1984, Jones 1970) has concentrated on the anthropologist being an insider in his native culture This concern has led me to reflect on my own field experience for this study There is the common view that native anthropologist, being so deeply steeped in the community under study, loses the capacity for objective evaluation of the situation. But the situation is not as straightforward as some critics would like to make it appear In my situation I was a Trinidadian studying Trinidadians, but a man studying women, a foreign-based student studying people living outside of my home district and a Hindu-Indian studying old as well as young women of all racial and ethnic groups I was familiar with the religious culture of Hindu Indians On the other hand, the culture of Africans that was known to me was gathered through readings videos, oral anecdotes, and brief glances at their way of life But since the "insider-outsider" distinction is not fixed or static, but ever-shifting and permeable social locations, it is possible for the native ethnographer to simultaneously adopt multiple dimensions (Naples 1996)

Khare (1983) states that the challenge of a native anthropologist is to treat the familiar with intellectual distance and "objectivity," to encourage him to discover the unfamiliar within his own society, and to handle it under an assumed familiarity Even in his own home setting, a native anthropologist experiences the paradox of intimacy by intellectually moving

back and forth, by being near to his people and far from them, and by linking the segments to make up a system as a whole which he had never seen" before Since my period of field research in Trinidad was divided into three seasons, I had the opportunity to distance myself physically and intellectually while being in Florida to discuss, reflect and analyze the situation before I went into the field again The experience of doing fieldwork in, and on, my own culture was balanced by the one-year period of writing the dissertation which was done at the University of Florida. It seems obvious that any anthropologist--native or otherwise--who has been properly trained in field research methods, and is armed with the proper theoretical tools, can produce good reliable data

The native anthropologist is at an immediate advantage not only because he knows the language but because he knows the nuances of that language variety I grew up in a culture where people, even at the highest educational level, felt most comfortable speaking Trinidad English Creole (Winford 1972) Words have different meanings in different cultural contexts. They can be used without connotations in one setting, and can be completely offensive in another For this reason, my interview schedule had to be revised after becoming more aware of, not only the idiom used, but also the subtle implications of these idioms For instance, "breastfeeding, had to be changed to "nursing," as "masseuse" had to be changed to the lady who-does-rub." The phonology of Trinidad English came naturally to me as was the syntax and structure of the language 'Jaundice' had to be pronounced as 'janders," as 'lying-in cold" had to be expressed as lining cold " In nearly all instances, I enunciated these idioms in the local dialect as well as in Standard English for fear that the better informed women would find me uneducated

The Indian informants identified with me most because we shared a common racial identity. On some occasions, Hindu women asked me if I were of the same faith. When I replied in the affirmative, they chided an educated man like me with disdain, as well as sympathy, for not knowing as much as they did about certain religious practices. The older women who were either home care providers or masseuses, saw my interviews with them as a contest of knowledge. They took the challenge in good spirits, laughed confidently and said, "I know you did coming with that" or "I know you trying to see how much I know." They were delighted when I asked them about things which were considered esoteric or which they thought I did not know about. For example, even after persistent probing to disclose the ingredients of a local fertility vaginal "plug,' they remained adamant. It was only when I began to itemize the ingredients myself that they provided the needed information--not before a burst of long laughing at the discovery of my knowledge. They also detailed the methods of preparation, application, and the results they have had with patients. Through this lively interaction, they discovered that I was like them, and yet not like them--I was married, I had children, and I was knowledgeable about the life experiences of postnatal women only to the extent that a man should know. Insider status can, therefore, be a mixed blessing. I could have easily been one of their relatives or neighbor to whom they could spontaneously reveal their intimate thoughts and sentiments. The older Hindu women addressed me affectionately as "beta" [son"], a good status for an ethnographer to be granted because of the learning role of a student-child (Agar 1980).

My informants, particularly the older Indian women, helped me because, in their eyes I was a son of the soil who had done well by being educated and had even gone abroad to do further studies. I had also returned

to my roots to learn about the local lifeways that had once nourished me and which are still sustaining them. My older African informants were helpful because they recognized that I was interested in their 'old time' health beliefs and practices to which their own children and grandchildren were either indifferent or critical. My younger informants saw me not so much as an insider, but as a returnee, distant from them by educational levels, and by foreign student status. I shared with my younger African informants a common age ranking, an identical language variety, the sameness of being Trinidadians, the ranking status of being married with child(ren), and often of the same color (see McClaurin 1996).

As a native anthropologist, I did not experience the traditional problem, which confronts all outsider anthropologists of adjusting to a new physical and social environment (see Frellich 1977). My knowledge of places, institutions, and people strengthened my insider posture (see Nakhleh 1979). I did not have to learn when I was approaching a Muslim informant that I had to use the appropriate greeting. My status as an insider afforded me a great deal of mobility and diversity in accessing sources of data, and consequently, in the credibility and general quality of the data collected. On many occasions, after studying my physical features, my informants would wonder aloud to another household member "I feel I know this boy somewhere you know." The expression of familiarity indicated a sense of social identification which would have been different with a typically foreign white anthropologist.

Data Analysis

Qualitative and quantitative data were integrated and conclusions formulated Each method contributed to a complete depiction of the variables involved in the research Both types of data were analyzed for patterns and consistency according to Bernard (1988) Descriptions of traditional maternal and child care were important because of the lack of documented information on this topic in Trinidad This method also allowed women in domestic settings to share, in their own words, their life experiences in caring for others and being cared for

Ethnographic studies of this nature done in urben settings obviously possess some limitations which could affect the accuracy of the research findings. First, the size of geographic area covered did not allow much interaction with my informants outside of interview sessions, except to see mothers completing their daily routines of childcare and housework. I tried to minimize this limitation through repeated visits and through observation of events and ceremonies in which my informants either attended or participated. Second, rural pockets like the cocoa growing village of La Cano, for example, did not at all represent the socio-cultural features of other districts of St. George Central. Third, since Mt. Hope Women s Hospital is a state-funded health facility, low-income women formed the vast majority of its clients. Fourth, the study excludes those women who delivered at private hospitals and clinics where permission to conduct research was denied. Fifth, some of the patients I wanted to meet in the ward were either asleep, sedated, in pain, or had left while I was not on site Sixth, I found that the hospital s registration clerk identification of the race of a patient problematic Any African who was not black of deep brown was labeled 'Mixed," rather than

"Spanish" (see Khan 1993). Seventh, the majority of patients (xx%) warded at the hospital were from the adjacent districts and were of African and Mixed descent. The number of Indians were proportionately small (xx%), and as such, I had to make adjustments to get this category of my informants representative of their proportion of the national population.

I used an ethnobotanical approach (see Schultes and von Reis 1995, Tarbes 1989) to collect data on traditional medicinal plants used by parturient women and their newborn infants during the postpartum. Grandmothers, masseuses and new mothers described or identified plants to me, and when the material was at hand, I collected and photographed them. I also tagged and pressed the plants in the field according to standard botanical methods. Taxonomic identification of voucher specimens was made by a botanist at the National Herbarium. An inventory of the plants used during the postpartum period was undertaken. Information on the family name, the vernacular name of the plants, the medicinal use, preparation of the remedies and dosage was obtained.

Photo-interviewing, or photo-elicitation, was one of the methods of research and analysis (Burns and Rocha 1991, Collier and Collier 1986) used particularly when dealing with body manipulation techniques during masseuse-patient interactions. A still camera was used to "take" notes of swift palm and finger movements during massage. The masseuses themselves often pointed out the inadequacy of explaining in words alone their manipulation techniques. They preferred to demonstrate on a nearby cooperative child, on my wife, on me, or even a doll. Photographs were also used as a reference point for discussions with these women, most of whom had never been to school and, therefore, used local idioms to indicate parts of the human anatomy. The pictures worked like a valid passport to cross social

barriers and bridge distance between strangers The visual images helped women to express themselves openly on sensitive topics like labor and childbirth. In dealing with this kind of ethnographic material it is necessary to qualify and support the spirit of the textual body with filmic images

The use of photographs relieved them of the stress of otherwise being at the receiving end of endless questions The photos, therefore, performed the role of a third person around which discussions took place The images were used to elicit comments from my informants on the "rightness of other masseuses techniques In using this approach of image content analysis, criticism could have been made openly, and without fear of the other party being present to get hurt one way or the other The photographs also served as a feedback medium which added to my integrity as a fieldworker and allowed the participants to become more involved in the study The text-picture format synchronizes verbal and nonverbal behavior and is even more objective than mere note-taking in the field

Summary

In this study, I take a critical medical approach in which I examine how macrolevel political and economic forces help shape medicine and its role in social and political life I dwell on, and move from, close encounters of postnatal women and their interaction with informal health care providers to the larger encompassing holism of the political-economic structure I also discuss the similarities and differences of explanations between traditional and biomedical systems with respect to postpartum care in Trinidad Differences in social class, religious affiliation, racial identity, gender orientation, generational variance, and educational levels are also explicated

I used multiple research methods to collect and analyze data, one of which included photo-interviewing or photo-elicitation. As a native anthropolgist, I reflect on my own field experience for this study.

Notes

[1] Caws (1974:9) defines explanatory models in general as belief systems that enable individuals in a culture to organize their perceptions of the world, make sense of personal experience and develop a framework which provides a guide for their actions. These models arise from the existing cultural milieu, and the socialization of individuals to their cultures.

[2] One of the many unlawful activities taking place at the time of my research was a case of false impersonification. A man acting as a U.S. Air Force recruiting officer deprived/fleeced prospective migrant-male workers of U.S. $5,300 "enrollment fees." He was sentenced to 38 years hard labor on fraud and unlicensed firearm charges (Burnett 1996:3).

[3] The formulae for the monthly and yearly hospital discharge analysis used by Mt. Hope Women's Hospital are as follows. The average daily census is calculated by dividing the total inpatient days for the month by the days of the month. The bed turnover rate is computed by dividing the total discharges (including deaths) for the month by the average bed count during the month. The percentage occupancy rate is counted by multiplying the total inpatient days for a period by 100. This number is then divided by the total inpatient beds multiplied by the days in the period (i.e. bed days). A patient day means 24 hours.

[4] Gurney (1991) argues that in some male-dominated settings, a female field-worker may not be taken as seriously as a man. This limitation may jeopardize the ultimate research goal of obtaining valid and reliable data.

CHAPTER 4
POSTNATAL WOMEN

Women rarely deliver their babies at home in Trinidad, except during an emergency. In 1990, approximately 97 percent of births occurred in biomedical institutions with a doctor or midwife present; two percent were supervised by trained midwives at homes, and one per cent by 'untrained handywomen" (Henry and Demas 1991:116). In St. George County where Mt. Hope Women's hospital is located, of the 5242 live births occurring for 1984, 3756 (71.3%) were in the government hospital (Mt. Hope?), 1244 (23.6%) in nursing homes, 169 (3.2%) were in private homes, and 73 (1.4%) in "other place" (MOH 1996:1031). The average monthly number of deliveries done for the four-month (June–September 1996) period that I spent at Mt. Hope Women's Hospital was 342. Parturient women generally disclosed that they felt safer in a hospital where a doctor was close at hand and was assisted by interns, nurses, technicians, and consultants, and where equipment is available such as incubators and oxygen tents, to cope with sudden emergencies.

The Postnatal Ward

The monthly average length of stay for postnatal women at Mt. Hope Women's Hospital between June and September 1996 was 1.62 days (38.9 hrs). The ideal length of stay in hospital is three days (72 hrs).

> In the West Indies, however, because of our social structure, close family ties and ready availability of

> experienced midwife help, mothers are often allowed home after 24-36 hours (Persad 1988:289)

The postnatal ward has a complement of 44 beds with an the average of 18 7 (42.5%) occupied per day, and a turn-over rate of 7 97 The average monthly discharge is 350 patients The population of women who use the services of Mt Hope Women's Hospital reflects the country's racial and ethnic composition. For July 1996, for example, of the 336 women in the postnatal ward, 147 (43 7%) were Indians and 189 (52.2%) were non-Indians Since, according to the 1990 population census, St George county has a population of 46,565 (24 9%) Indian females, there is good reason to believe that about half of the women admitted to Mt. Hope reside outside of the county and are using false addresses to access the facility It is also possible that they are referred to the hospital by their respective physicians.

The postnatal women are usually dressed in a soft, thin "nightie" or a 'duster," and they all wear "slippers" of either rubber or synthetic fur On the bedside is a carrying bag in which are kept clothes for the baby and themselves, and toiletries which the hospital may or may not provide As fellow parturients, they talk to one another and compare their past and present experiences of pregnancy, labor, childbirth, breastfeeding and postpartum. They talk while lying on the bed, sitting on it with their feet on the floor, or while sitting on the two or three steel chairs which are placed near the open windows They shuffle to the bathrooms and to the coin-operated telephone booth located at one end of the ward. Postnatal women in the ward assist one another in fetching items from the bedside table They establish friendships which are born from the common experience of labor and childbirth. The friendship may grow outside the hospital setting, or may be aborted after they are discharged Most of the time is spent lying on the bed,

sleeping, expressing milk manually, or breastfeeding the newborn infant To avoid the embarrassment of my presence as a man, I looked more at my notebook than at the women when I introduced myself and asked their permission to participate in the research project

Postnatal women's rest is sometimes disturbed by the clatter of broom, bucket and mop as the maintenance staff cleans the floor The sound of other patients groaning in pain, or the cries of a newborn in the same room, sometimes aggravated the mother s own disturbed physiological rhythms Since serious complications may arise in the early postpartum period, women are asked by the obstetricians making his rounds to respond to checks of the fundal height of the uterus to ensure that involution is occurring normally Their lochia is also observed and the volume, color, and odor are noted In post-cesarean section patients' urine output is checked, and the lower limbs are palpated for any tenderness thet might indicate venous thrombosis (see Persad 1988:289) Recuperating parturient patients are sometimes awakened by the assistant nurse to take their blood pressure, temperature, and pulse, and to examine their breasts and their perineum A few women told me thet nurses in the ward are sometimes noisy as they participate in the national lottery 'Play Whe" game The nurses become excited, at times, as results draw near on the radio They hurriedly make phone calls to someone to place bets for them at the very last minute, discussing and debating, in the process, what number they think will be the best selection. Patients are also awakened when the staff nurse is distributing meals The nurses are plagued with requests by women to use the hospital s private telephone to inform their relatives thet they have been discharged and should come to take them home These requests, which are often refused, are generally made when the patients do not have coins

On no occasion is a discharged mother allowed to leave the ward unless she assures the nurse that a car is taking her home. The reason why she is not allowed to use public transportation was not clear. When postnatal women are ready to leave, they repack their bags, push the cot with their babies and wait until the nurse at the station has time to talk to them. While standing, often with the child father, they are instructed in less than five minutes by the nurse to walk with the child in the sunlight during the early morning, and how to recognize symptoms of infant jaundice. They are advised to cover the baby's head properly to prevent the contraction of cold, and to use mentholated spirit to clean the umbilical cord. They are also informed to change their 'pads' regularly, and to breastfeed their babies every three hours. Some nurses suggest that new mothers should take "iron tablets" and drink lots of fluids. Those who have lacerations or episiotomies are told "to keep the area dry" and to visit a doctor after two weeks to ensure that healing is satisfactory. Those who have had episiotomies are told to have daily sitz baths with salted boiled water. Other patients are advised to visit the clinic in their area at about six weeks postpartum. Information given to women being discharged vary in length and detail depending on whether the mother is a primipara or experienced multipara, how dedicated the nurse is to her profession, and how preoccupied she is with official or personal matters.

The Nursing Staff

Forms of identification (name-tags) are not worn by any category of nurses at Mt. Hope Women's Hospital because they were not provided by the administrative authorities. The occupational status of nurses is divided into

the Matron, Ward Sisters and registered nurses who all wear white uniforms without any red stripes demarcating rank. Nursing assistants however, wear cream uniforms. Their role is confined to basic bedside duties like "doing dressings," taking blood pressure and body temperature. They are not allowed to administer medication or give injections. The hospital maids, who wear dark-brown uniforms, are responsible for janitorial duties. Nurses from the "birth department" sometimes visit the postnatal ward in their dark green uniform. I was told that they are suppose to change their clothes after each delivery to prevent the transmission of infections.

Nurses in the postnatal ward at Mt. Hope Women's Hospital assume that parturient women have received instructions during their antenatal sessions with the district nurses. Therefore, they should only have to remind new mothers about the rules of maternal and child health care.[1] Of the 210 postnatal women I surveyed, 90 (43%) were primigravida and 120 (57%) were multigravida. Figure 4-1 illustrates the number of mothers who recalled that certain topics were discussed with them by nurses while resident in the postnatal ward in the hospital. The majority of women (31%) recalled that breastfeeding was the topic most frequently discussed with them, and was followed by instructions on walking the baby in the early morning sunlight (25%). Only a small percentage of women remembered being informed about the benefits of postpartum exercise, birth control, and sex (7%, 6%, and 4% respectively). Some patients theorize that the nurses expected that the baby's grandmother would give the new mother advice on postnatal care at home. They add that this assumption relieves the nurses of that responsibility in the hospital.

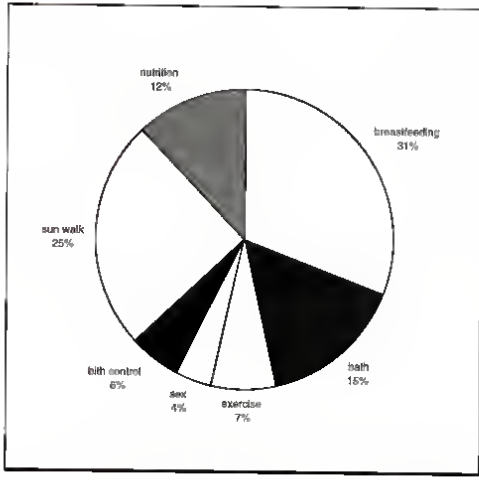


Figure 4-1 Number of patients (n=64) who recalled topics being discussed with them by hospital nurses

The vast majority (87%) of the women I interviewed were quite satisfied with the attitude of the nursing staff at the Mt. Hope Women's Hospital. They described them as "allright, fine," "very/good" kind, understanding, and patient.[2] Birthing women know the unwritten hospital code that the response of nurses depends on "how you behave" when in pain, and that to be stoic and silent would guarantee good treatment."

Of the 210 hospital records of postnatal women I randomly examined, only 13 (6%) were observed by the midwives to have been "uncooperative, very uncooperative" and/or "noisy." The patients in this category were almost an equal mix of primigravida and multigravida women with only three of the 13 being teenage mothers. One adult was noted as exerting "poor maternal effort," another as "noisy and distressed during contractions," and the other was "uncooperative" with a breech male fetus in her womb. This infant was delivered via LTCS. A 35-year old primigravida woman, who was in labor for 21 hours, and who had borne twins through spontaneous vertex delivery, was described as exhibiting "fair behavior and response." A 19-year old primigravida woman was "uncooperative" to the extent that she "knocked the nurse away." In the labor ward, teenaged unwed mothers are reported to be treated harshly. The nurses rebuke them when they cry out in pain, saying that no one had told them "to get into this" (Teenager 1994 9).

There are a few bad experiences suffered mainly in the labor ward by women who report that they delivered by themselves without nurses in attendance, or with nurses present but who bluntly refused to help (TE 1993 3). Though these are isolated cases, they should not be overlooked. In the postnatal ward, I observed that the nursing staff appeared to accept, as a matter of course, that patients should make few demands, and were rather

disturbed by the occasional patient who did not conform to this expectation. On more than one occasion, I witnessed a woman come to the station to inform the nurse that her room-mate was in severe pain, could not move, and had sent her to fetch the nurse. After receiving the message, the nurse responded by saying, "Tell her to come."[3] Patients report that some nurses suck their teeth ("steupsing") in anger when they discover that their personal bags are lacking essential maternity items like enema, clothes for the newborn, a baby blanket, disposable diapers, and towels.

In the privacy of her home, a 30-year-old "Spanish" mother of a deceased preterm male infant, related her experience to me. She was in pain in the labor ward of the Women's Hospital when she drew it to the attention of the nurse that she was "feeling something coming out like the baby." The water broke suddenly, and the nurse rebuked her saying, "Look at this mess you make in this bed. I better make you clean it for yourself." The bed was bloody and the nurse threatened her: "I will leave you in that same bed." The male attendant ("wardman"), who was present, pleaded rather firmly: "No, you can't do that." On his own initiative, he helped the parturient woman shift from one side of the bed to the other, while he himself changed the soiled sheet for a dry one which he pulled from a nearby empty bed. The nurse in charge, (whom she secretly nicknamed "Black Bird" because she was a jet black woman in white uniform) merely walked away. The Spanish woman recounted that patients in the ward, some of whom had just undergone surgery for fibroid, brought bed pans for her use. She said she felt much pain and humiliation.[4]

A few hours after delivery when the Spanish woman inquired about her baby who was taken from her to the Intensive Care Unit, the nurse told her abruptly to "wait." It was not until about ten hours later that she was able

to see her baby in the incubator with "his mouth open," a tube in it, and needles stuck in his limbs. His fingernails and feet were blue. She was told that he had died of respiratory failure. When her sister requested to visit her in the postnatal ward outside official hours, a nurse informed her that only the father of the child would be allowed. But the father was in Surinam as a migrant worker.

The interaction between nurses and women at public health facilities in Trinidad would frustrate many feminists who expect that female caregivers would be tender, humanistic, nurturant and empathetic (see Waller 1988). One letter-writer (Hernandez 1993:7) in the local newspaper comments accordingly:

> On a primary level, tha very fact that Mt. Hope is a facility for women, staffed for tha most part by women would naturally lead to tha expectation that a high degree of sensitivity will permeate the quality of care given when a woman is at her most vulnerable. Yet women repeatedly tell of insensitive treatment by hospital staff. If we are to dismiss about half of these stories as ramblings grounded in paranoia and half of what's left as misinterpretations of events, due to intense pain of the birthing process, that leaves a sizable percentage of instances when the hospital does not measure up to one of emotional care of the woman during a particularly delicate period. This leads us to explore the issue of whet is tha definition of CARE as practised by our maternity units. And it would appear that the philosophy of these facilities is analogous to a birthing factory where women come in to have babies and little else.

In 1994 in another ward of the Women's Hospital, one woman (Quiniou 1994:10) was emotionally hurt by the callous attitude of the nurses. She wrote: "Nobody should be treated like this because they are ill. It's as though everyone in that ward had done something wrong and was being

punished." The horror stories emanating from patients at the public hospitals and health centers indicate that the quality of care in the public health care system leaves much to be desired. The humiliation which patients suffer arises from the inhumane and undignified treatment meted out by the nurses who prefer to "engage in idle gossip" (Bailey 1995:6) than comfort people in pain. Since the vast majority of patients in the public hospitals are either unemployed or low-income owners, they have few options when the nurses treat them with such callousness, utter contempt, and uncaring disrespect.[5] The insensitive attitude of the nurses is one of the main reasons that force people to turn to private medical centers that charge exorbitant fees which only a minority of patients can afford to pay.

Episiotomies and C-sections

All the women I interviewed understand that an episiotomy is an incision made with a pair of scissors in the perineum to help the baby to pass through the birth canal. Both patients and nurses in Trinidad refer to episiotomies as "stitches," which they know are really sutures to the skin and muscles that are made under local anesthetic. My postnatal informants were not aware of the feminist view (e.g. Kitzinger 1980:251, Stoppard 1994:189) that a first degree tear [that is, a surface one] heals better and is more comfortably than an episiotomy. If done too early--before the perineum has thinned out--the episiotomy can cause unnecessary bleeding and sometimes the cut is larger than the tear would have been. Feminists (e.g. Kitzinger 1995:156) also maintain that an episiotomy serves as another example of patriarchal (medical) power over women which give them "the right to torture and use women's bodies in any way they like."[6]

In a study (Phillips 1996) done in 1990 in the obstetric and gynecology wards of four public hospitals (including Mt Hope) in Trinidad, the researcher found evidence of professional dominance in the interactions between male doctors and their patients Professional dominance is interpreted as inadequate communication of information to the patient, an apparent insensitivity to the patient's condition, evasion of direct questions, deliberate use of medical jargon, and the expressed unwillingness to give information Since 90 percent of the doctors were males and all the patients were females, the interactions constituted gender, class and even power relations as well

Obstetricians at Mt Hope Women's Hospital are of the opinion that an episiotomy helps the delivery process under certain circumstances This opinion is clearly expressed in the notes they make on the patient's medical record form [Appendix B], for example "[The] patient had a spontaneous vertex delivery of a live-term female infant [which was] aided by [an] episiotomy" Of 122 (58%) cases of women (n=210) who did not receive episiotomies at Mt. Hope, only 19 (16%) suffered 'bruises' or lacerations in the perineum, most of which did not have to be sutured Since I did not get permission to examine patients' records at private hospitals in Trinidad, I can only assume that obstetricians perform a higher rate of episiotomies (and c-sections) than at the public hospitals At Mt. Hope, of the average monthly discharge of 350 postnatal women for the months of June to September, 1996, 88 (25%) received episiotomies Of the 210 medical records of women I randomly examined, 43 (20%) sustained episiotomies. Twenty-one (49%) were first-time mothers. The American College of Obstetricians and Gynecologists (ACOG) estimates that as many as 90 per cent of women giving birth to their first child in a hospital will have an episiotomy, despite ACOG's

official position that "the routine use of episiotomy is not now recommended as a standard practice" (cited in Griffin 1995:57). Clearly, obstetricians at Mt. Hope do not support the view that an episiotomy is a necessary procedure for most primigravida mothers.

To help the healing process of the lacerations, which takes about 21 days for deep tissue curing (Hull *et al* 1986:287), women are advised by Mt. Hope nurses to take daily sitz baths with salted warm water. As a form of recovery, elderly care-givers prescribe a brew of hog plum leaves boiled in cooking salt to prevent infections, and to ease postpartum pain. It is believed that "the steam (heat) from the boiled bush[es] would heal the stitches faster and better." In the bathroom, the new mother on her own, or under the supervision of the child's grandmother or masseuse, lightly presses the area between the rectum and the vagina with the leaves twice daily. She is advised to sit over the basin of water "as long as she could bear." The treatment begins from the day the new mother is discharged from the hospital until the ninth day postpartum. This motion of rubbing, according to biomedical opinion (see Cronk and Flint 1989:86) "helps her to touch herself again, and the massaging encourages circulation and so promotes healing." The sensation of the burning in the perineum during the sitz bath, and during massage, is believed to be an assurance that the therapy "is working." The act of squatting twice daily can be considered a form of postpartum exercise which strengthens the pelvic floor muscles. This benefit was not recognized by physicians I interviewed.

The mean rate of cesarean sections at Mt. Hope Women's Hospital is 10.14. Of the 210 women's records I surveyed, 32 (15%) underwent c-sections of which 11 (34%) were Indian. Fewer Indian than non-Indian women are being 'cut' partly because they are more likely to seek the services of (mainly-

Indian) masseuses who rotate the fetus externally when it is near term so that it turns head down and bottom up (see Chapter 5). Mt. Hope seems to live up to the expectations of many child birth educators and women's groups who expect that cesarean rates should not exceed 15 percent (Haupt 1996:104; Kitzinger 1994:157). Cesareans now account for as many as 25 percent of all deliveries in the United States (Haupt 1996:104) and 20 percent in Canada (Carlsone *et al* 1996:134), about a half of which are deemed unnecessary. These rates are very high compared to other industrialized countries like the Netherlands, Japan, Slovenia, and the former Czechoslovak Republic which have a rate of 6-7 percent (Macfarlene and Chamberlain 1993:1005). Studies (e.g. Kitzinger 1994) also reveal that cesarean rates are higher when deliveries are supervised by doctors rather than by professional midwives.

Macfarlene and Chamberlain (1993:1005) argue that monitoring of cesarean rates is one way to take the pulse of obstetric practice, it is also a key factor in any form of obstetric audit for comparative studies. A former WHO official disclosed that obstetricians are performing too many "unnecessary" c-sections in private hospitals in Trinidad for monetary ends (Rostant 1997b:5). Based on statistics gathered from WHO, PAHO, and the Ministry of Health, he claimed that while public hospitals were delivering ten percent of births by c-sections annually, private "nursing homes" were doing between 23 and 33 percent. He added that many deliveries in these private hospitals were "unnecessarily induced" and done Monday to Friday between 9 a.m. and 5 p.m. to suit the convenience of the doctor.

Other critics (e.g. Clark 1984) charge that some doctors, particularly in developed countries, also schedule c-section deliveries for their own convenience, that they make more money for themselves and the hospital, and that they are less at risk to be sued for malpractice when they resort to this

form of surgical procedure It is safe to assume that richer women in Trinidad are more likely to undergo c sections than poorer women (who visit the public hospitals for deliveries) because of economic motives on the part of obstetricians. In Brazil, for example a national average of 31 percent of the women--most of them being higher-income women--were being cut in 1981 Doctors were abusing the use of modern surgical technology to make more profit and to enlarge the hospital industry in which they owned shares (Barnum and Kutzin 1993)[7]

The doctors at Mt Hope Women's Hospital are not always meticulous in their note-taking/making on patients medical reports Of the 32 records of cesarean-section patients I examined, 10 (31%) did not have any descriptive comments except the acronym "LSCS ' Three exceptionally detailed remarks were: "Extraction of live male infant (breech presentation)," "Emergency LSCS performed due to failed induction and fetal distress Infant extracted at 12.20 a.m.," and "Uterus and abdomen sutured in layers" Most of the remarks were explanations why the surgical interventions were necessary The number of explanations were almost equally divided into 'failure to progress," fetal distress," 'breech presentations," "twin births," and "diabetic" The records show that the three Ps were most common reasons why c-section was performed tha incompatible size of the passenger and the pelvis [pelvis cephalopelvic disproportion], especially when fetuses are breech, and the lack of progress when the cervix does not dilate The reasons why c-section surgery are performed on women are never fully explained to them after they recover (see also Phillips 1996) The records of patients are also never disclosed, even in culturally-meaningful cases when infants are born with a 'veil" over their heads

All the women with c-section births I interviewed view this kind of major surgical intervention only as a last resort. Based on what they have heard from a number of sources, they worry about the possibility of death and the accidental injury to surrounding organs. They shudder at the memory of a catheter being inserted into their bladder, blood loss, and the intravenous tube which remains in place for a day or two. They recall the gnawing abdominal pains, the groggy feeling after the anesthesia has worn off, and the longer hospital stay. They worry that the surgery may lead to blood clots in the pelvic organs. The operation also debars them from resuming routine work, and from lifting heavy objects for six weeks postpartum. The appearance of the scars left on the surgical site is unpleasant to them. And most of them believe in the false old dictum 'Once a cesarean always a cesarean."

To alleviate these anxieties and prevent the incidence of surgery, all the women interviewed say they turn to prayer. Some with breech pregnancies visit the village masseuse who repositions the fetus through massage and manipulation. Only a small minority attend Lamaze and other child-birth preparation classes, which studies (e.g. Haupt 1996:104) in United States have shown to result in a slight decline in c-section rates. Emotional support, provided by an elderly woman at the bedside of the birthing patient, has also been shown to reduce c-section rates considerably and diminish the need for pain-blocking medication (Nolan 1995). If obstetricians in Trinidad and elsewhere, are genuinely concerned about the welfare of patients (often of the opposite sex), they should organize child-birth preparation classes and open the labor-room door to the village masseuse who would provide the much-needed emotional support for patients (see Chapter 8). This intervention would validate a traditional belief that an experienced female

companion should be present at the birth site, which would, among other things reunite the ties that bind women together in crisis

Perinatal Mortality[8]

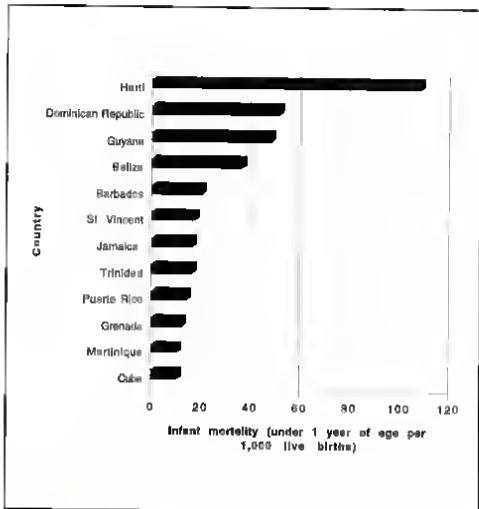
Based on calculations I have made for 1996, Mt Hope Women's Hospital has an impressive mean maternity mortality rate of 15 deaths per 100,000 live births. The national rate for 1983 was 54 females per 100,000 live births (Henry and Demas 1991:77). Since I do not have detailed records of maternity deaths[9] at Mt. Hope in my survey sample, I am forced to rely on the findings of studies done elsewhere to observe national trends. Qualitative literature on maternal deaths in Trinidad is almost non-existent. Analysis of available information (PAHO 1991:30-31) in the Americas exhibits significant differences among the countries. Costa Rica, Cuba and Uruguay for example, show rates of 26 deaths per 100,000 live births while Haiti Paraguay, Peru and Bolivia reveal death rates of 230, 270, 303, and 480 per 100,000 respectively. Of the approximately 500,000 maternal deaths occurring in the world each year, almost 99 percent take place in developing countries. However, there has been a general decline over the years, though the main causes of death--toxemia, hemorrhages, clandestine abortions, and puerperal sepsis--remain the same (Sagewan 1992:272, Taucher 1992:15).

According to Mt. Hope medical reports, the neonatal death rate at the hospital for 1996 is 22.5 per 100,000 live births. Information is not available on neonatal deaths, specifically, in other countries of the Caribbean. What exists is data on death rates of children less than one and five years of age (Figure 4-2). The mortality rate of Trinidadian children under five years fell from 40 per 1,000 live births in 1980 to 23 per 1,000 in 1990 (TG 1990:7). This rate placed the

country in the fifth lowest death rate category for children under five years in Central America and the Caribbean. Data for other Caribbean countries such as Belize, Guyana, St Kitts-Nevis and Jamaica show that their rates range between 18 and 38 per 1, 000 as compared with 8 1 per for Canada and 11 for the United States (LeFranc 1990 4)

Perinatal complications is one of the major causes of death of infants in Trinidad (PSTT 1989 7) The other causes are heart defects, accidents poisonings, and chromosomal abnormalities Infant deaths in the postneonatal period are caused most frequently by congenital anomalies, pneumonia, accidents, and intestinal infections (PAHO/WHO 1994 416) Of the 528 children under the age of 15 years who died in Trinidad in 1986, 355 (67%) were under one year, the vast majority of whom died because of perinatal problems (PSTT 1989 7) Neonatal deaths occur mainly because of maternal bleeding Babies whose birth weight is less than 2.5 kg (5lb 8 oz) are five times more likely to die as those who have normal weight According to United Nations data (cited in TG 1990 6), about 23 out of every 1,000 children born in Trinidad and Jamaica do not live past their fifth birthday Though the two countries have the lowest infant mortality rate in the region, these deaths were caused by childhood diseases thet could have been prevented if the infants were adequately immunized and otherwise protected (MOH 1996:7) The diseases thet top the list are diarrhea (caused mainly by gastroenteritis), acute respiratory infections, vaccine preventable diseases, and malnutrition

Again, I do not have sufficient data on perinatal deaths at Mt Hope Women's Hospital to determine age, sex, educational and ethnic differences



Source. U.S. Bureau of the Census 1994.

Figure 4-2 Infant mortality rates for selected Caribbean countries

on mothers in order to arrive at empirical observations. The 1996 hospital records are, however specific on the number and gender of still births. The data show that still births comprise 17.7 per 1,000 live births, with female fetuses dying at a slightly higher rate than males. In other developing countries, more girls seem to outlive boys during the first year of life (UN 1995:67). If gender differences for infant deaths in Trinidad are consistent with other developing countries then this finding supports the widespread folk observation among elderly grandmothers that "boys get sick faster than girls" they need more care," and "little girls stronger than boys".

A Demographic and Health Survey conducted in Trinidad in 1987 reported that infant mortality rate was 42.9 for the children of adolescent mothers compared with a rate of 28.4 for the 20-29 age group (UN 1995:67). This ratio is comparable with the 2.1 proportion reported internationally. This high rate can be explained by the fact fewer teenage mothers attend antenatal clinics than women of older age groups. In another study on Trinidad (Ebanks 1984:30), it was discovered that women with a secondary level of education and above had relatively low infant/child mortality levels compared to those with only primary education.

In another (fertility) survey (Harewood 1978) done in Trinidad in 1970, it was found that the frequency of infant deaths was higher among Indian than African mothers. In my selected sample frame of 336 postnatal women, about eight percent of the live-birth infants of Indian mothers had died as compared to five percent African mothers. This ethnic difference can be explained by the demographic location and poverty levels of the Indian population. Most Indians live in the rural areas of the island (Clarke 1986) which are characterized by fewer biomedical facilities, and higher poverty levels (21%) when compared to urban areas (2%) (ILO 1995:106). Ebanks (1984)

disputes this socio-economic variable and does not offer any explanation(s) himself. He, however, finds that Indian infant mortality rates are generally higher in the rural areas.

Fertility Rates and Teenage Mothers

Fertility levels in Latin America and the Caribbean have declined significantly over the past two decades, dropping 40 percent or more in 13 of the region's 33 countries. The total fertility rate has fallen from 4.8 to 3.2 in the region (UN 1995:xviii). My examination of 336 records of postnatal women at Mt. Hope reveals that African women have a slightly larger number of children than their Indian counterparts. While African mothers have an average of 2.4 children, Indian women average 2.3. This figure would be slightly larger than the present national average because the percentage of low-income women at Mt. Hope is over-represented. But generally, fertility levels have been declining over the years among all ethnic groups in Trinidad.

My figures are, nevertheless, consistent with previous fertility rates calculated by others. In a survey conducted in 1990, for example, Henry and Demas (1991:73) observe that African women bear more children than Indian women and women of Mixed descent at a rate of 3.5, 2.8 and 3.4 respectively. The comparably lower fertility rate of Indian women is a reversal of past trends in which they were bearing slightly more children than their African counterparts. Harewood (1978) posits that the lower number of live-born children, as well as of pregnancies, among Indian women is partly due to ethnic differences in mating patterns. National fertility surveys (e.g. Abdulah

1991) reveal that there are no significant ethnic differences in the ideal number of children women thought a mother should have

The fertility rate in Trinidad increases dramatically in November-December, which is approximately nine months after the annual Carnival frolic (Diptee 1991) The government census figures reveal that there is usually a two percent increase in the birth rate after young drunken semi nude revelers perform gyrating dances late into the night. The dramatic increase in "Carnival babies" continues to this day despite the well-publicized campaigns that Carnival is a festival of creativity rather than a season for procreativity A study to determine the nature of the relationship between "the child father" and the mother of the baby-boomer would be an exciting enterprise.

I am not aware of any kind of research that was done in the Caribbean on fertility rates of women who were/are involved in racially mixed sexual unions Demographic surveys (e g Harewood 1978) in Trinidad are often confined to the study of women who are themselves racially "mixed" [commonly called *douglas*], and who are often classified in the "non-Indian" category Data at Mt. Hope Women's Hospital reveal that of 336 postnatal women, 29 (8.6%) Indians have given birth to at least one child for a men of African descent (Figure 4-3) This figure is almost halved by African women: 12 (3.6%) of whom have a sexual partner who is Indian In other words, the data indicate that nearly twice as many Indian women are cohabiting with African men as compared with African women are mating with Indian men. The 8.6 percent figure for Indian women would be higher than the national estimate because my figures are drawn from data on women living mainly in

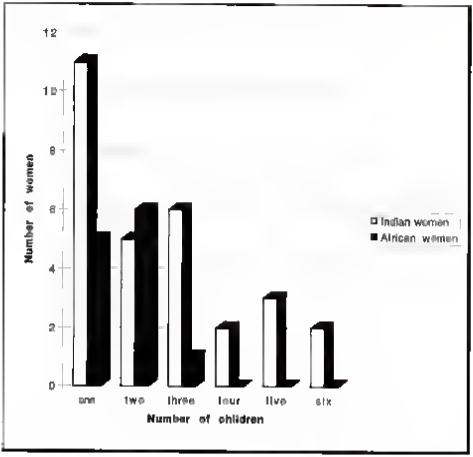


Figure 4-3 Fertility rates of women in racially-mixed unions (n=41)

the East West corridor which is largely dominated by Africans It is interesting to note that the fertility rate of Indian women in mixed sexual unions is considerably higher (2.6) than that of their African counterparts (1.6) A popular postulation for this fertility differential is that the African man "feel[s] so insecure of the Indian woman leaving him that he has to give her a string-band of children to keep her tied to him."

Data from Figure 4-3 show that more African women in Trinidad have two children in a racially-mixed union when compared to their Indian counterparts Indian women, however, outnumber African women in all the other number-of-children categories If my calculations have an unacceptable large margin of error, then it still holds true that more *dougla* women are cohabiting with non-Indian men than non-Indian women with Indian men.[10]

There are some other variables related to fertility levels which have been noted in past surveys As may be expected a 1977 survey (WFS 1981:8) revealed that younger women had a higher fertility average than their older counterparts There was no disparity in teenage fertility rates among the different ethnic groups--they all averaged 0.6 child per woman. It was only among women aged 20-24 that there were some differences Indians averaged 1.4, and non-Indians averaged 1.1 children. Concurrently, common-law women had a higher fertility level than married or visiting women. Rural areas had a somewhat higher average than urban areas. In the 1987 demographic and health survey, there was a sharp increase in the age at first birth (birth of the first child) for all ethnic groups (Rampersad 1989:20) The sharpest increase occurred among Indian women, which could have been partly responsible for their lower fertility rate and higher contraceptive use A similar survey conducted in 1990 showed that the fertility rate was slightly

higher in rural than urban areas. Fertility differentials were also seen when educational background was considered, whereas women with less than completed primary education had four children on average, those with completed secondary certification had 2.3 children each (Henry and Demas 1991:73)

Teenage or adolescent fertility rates in the Caribbean and Latin America are high (Bureau of the Census 1994:3, UN 1995:xviii) Trinidad is no exception with a rate of 142 per 1,000 (3,400 births) according the latest (1990) government report (Tull 1995:1 & 7) These rates have fluctuated over the past decades from 98.7 per 1,000 live births in 1970 and 69.6 in 1989 to an increase of 138 per 1,000 in 1990 according to another report (Sharpe and Bishop 1993:10) The number of mothers under 20 years old in Trinidad is keeping abreast with the 180 per 1,000 statistic in Latin America (UN 1995:xviii) Based on a selected sample frame of 336 postnatal women at Mt Hope Women's Hospital, my calculations reveal that the number of teenage mothers is 175 per 1,000. Other researchers (e.g. Barker and Saint-Victor 1992:145) who did work as far back as 1985 have found that young women between the ages of 15 and 19 account for approximately 250 per 1,000 of all births. Of the 59 (17.5%) teenage mothers in my sample at Mt. Hope, 43 (73%) were of African descent and 16 (27%) were Indians. More than one-third of Indian teenage mothers were impregnated by non-Indian men. This finding disputes the claim by Jagdeo (1984:12) that teenage pregnancy in the Caribbean is unrelated to ethnicity because there are no statistics verifying this."

Postnatal Women in the Family

Family organizations in the Caribbean are formed by socio-economic as well as by historic and ethnic factors. Three types of union have been recognized in the English-speaking Caribbean. They are legally registered marriages in which the couple resides together; common-law unions where the couple shares the same residence but the union is not registered and visiting extra-residential relationships in which the man visits the woman's home frequently to engage in sexual intercourse. The last type of conjugal union is highly unstable but the man contributes to the support of the woman and his children. Union formation patterns in Trinidad are a very complex social and cultural phenomenon. The difference between the African and Indian families reflect, essentially, the patriarchal forms of the Indians in contrast with the female-centered patterns of lower-class black women. African family life is characterized by highly unstable sexual relationships, low marriage rates, high illegitimacy rates, and female-centered households which contain a woman, her children and grandchildren (Smith 1979). Although marriage is seen to be the ideal norm for women of all ethnic groups in both common law and visiting unions, for African women in particular, adult status and feminine identity are based on motherhood and not marriage (Safa 1986). Among low-income African women, marriage is more likely to come long after their children have grown up (Pulsipher 1993).

Trinidad (and Guyana) has more co-residential unions than the other English-speaking Caribbean countries because of the high rates of marriage among Indians. According to a 1990 survey (Henry and Demas 1991:72), the population in co-residence is nearly alike among the three major ethnic/racial groups—African, Indian and Mixed. However, more women of

Indian descent tend to be formally married (54%) rather than living together or visiting (14%), while the reverse is true among African women (27% in formal unions and 43% in less formal arrangements). My data, drawn from Mt. Hope Women's Hospital medical records between June and September, 1996, indicate that 75 percent of Indian parturient women claim that they are legally married. Does this mean that there is a dramatic increase in the rate of Indian (particularly Hindu) marriages in Trinidad since 1990? Probably not.

What seems to be a likely explanation is that the Indian/Hindu taboo of having a child outside of wedlock has pressured many expectant mothers to choose this socially and culturally sanctioned category of marital status. The expectant mother wants the child to be registered as "legitimate" in the birth certificate and the hospital registration clerk has no way of validating this information (see Appendix B). Thus, if authentic common-law residential and visiting unions are registered as "married," my 75 percent figure would approximate the 68 percent (i.e. 54% + 14%) found in the 1990 survey. Still, there seems to be an increase in the rate of Indian marriages.[11] The fact that Indian women have a higher rate of formal unions--which in 1970 have been found to be the most stable union types (Harewood 1978:141)--provides them with the opportunity to bear a child "legitimately" and to return home to their stable residential partners (husbands) after hospital discharge.

While most researchers (e.g. WFS 1981) concur that common-law and visiting unions play a relatively modest role in the mating patterns of women of Indian origin, they have failed to bring their analysis to bear on the various ethnic groups within the Indian community. Based on my 1996 Mt. Hope data, I have found that postnatal Indian women who are not in legally registered unions are more likely be Christian in religion. About half (45%) of

the Indian mothers who are Roman Catholics are not legally married, and one-third (33%) of other Christian Indians were also in common law or visiting relationships. These figures contrast with the small number of Hindu (21%) and Muslim (22%) women who have given birth to a child outside wedlock.

If Hindu women who are in common-law relationships do not marry, it is usually due to one of two things. It is either that one of the two parties is still not divorced. Or, that the woman may not choose to remarry (ceremonially or officially) in recognition of the community's beliefs that a Hindu woman can marry only once, and that a Hindu bride should be a virgin.[12] The reason why fewer Hindu and Muslim women bear children outside an officially sanctioned union is that there is thedeep-rooted taboo of illegitimacy within their respective religious/cultural traditions. In discussing the age of entry into initial marriage, Roberts and Braithwaite (1962:234) do, however, remark that "the very small number of East Indian women who fail to establish themselves in early marriage are almost wholly not of Hindu religion".

There is no researcher to my knowledge, who has done a study on the types of sexual unions of women who are involved in racially-mixed child-bearing relationships in Trinidad. My data, drawn from 336 patients records at Mt. Hope Women's Hospital, show that only about one-third of African and Indian women who cohabit with men of another race were formally married. African women were slightly more inclined to marry their Indian bedmates than their Indian counterparts (38% compared to 33%). This is an indication that racially-mixed sexual unions are still not socially sanctioned in the politically and ethnically polarized society of Trinidad. One indication of this is the proportionally small number of photographs of mixed married

couples appearing in the wedding pages of the daily newspapers. It seems that partners of racially-mixed unions find difficulty in getting their respective parties to come together in the church/temple/mosque grounds to approve the 'unholy' matrimony

Compared to Hindu and Muslim women, Christian Indian women are more likely to engage in common-law and visiting unions as well as in sexual relationships with non-Indian men. Clarke (1971:215) observes that, like Africans, and unlike Hindu or Muslim Indians, the parents of Christian Indians have less control over the choice of their children's marriage partners He states that children of racially mixed marriages are more likely to adopt their mother's religion if she is Christian, and are less likely if she is Hindu or Muslim I would like to add that postnatal Indian women in mixed-marriages are more likely to go to their nuclear homes after hospital discharge, less likely to go to their partners parents' home, and the least likely to go to their natal home to spend the puerperium Hindu and Muslim women in mixed unions do not, therefore, receive the ritual and ceremonial accolades usually conferred upon those who marry within their race and religion

African women of child-bearing age in Trinidad are more likely to be involved in common-law and visiting unions than their Indian counterparts (Harewood 1978:122, WFS 1981:8) Formal marriages, therefore, represent only a minority of sexual unions among African women What this means for postnatal African women is that the presence of 'the child father' in the home during the puerperium is not always guaranteed Senior (1991) argues that the absence of the African father in the family in the Caribbean has become such a common feature that society itself sometimes takes for granted Compared to Indian women, the child born to an African woman is

more likely to be an 'outside child' of an African bed-mate. This child is considered "illegitimate" according to legal union status but also because it was conceived (often covertly) by a man who is married or common-lawed to another woman. In visiting types of relationships, the father is likely to have minimal contact with the postnatal mother and the newborn. Research (Bell 1970) in the late 1960s indicates that African fathers were more involved in feeding, playing, holding, bathing, and changing diapers than their Indian counterparts. The fact that Indian mothers expected their husbands to contribute more to the care of the children at that time, reflected that they had begun to challenge men's traditional role in the family.

Green (1964:14) observes that in the 1960s while African mothers were more likely to leave their children in the care of others, Indians were ever-present protective and indulgent. He notes, too, that Indian mothers

> would drop dinner preparation or chatting with friends to give the child the attention he wants. It would seem that East Indian mothers feel their primary duty is to care for the child's happiness and well-being at the expense of other responsibilities and desires. The majority of East Indian mothers would not leave their little ones in the charge of outsiders, however responsible a good woman may appear to be.

Indian women were also seen to breastfeed their infants longer and more on demand and more apt to hold them in their arms (Green 1964:16). This responsibility upon themselves made their housework harder. Women with children in visiting unions are often female heads of households engaged in income-generating activities outside the home (Massiah 1983, Merrick and Schmink 1983, Safa 1992). Most of them in Trinidad are of African descent (WFS 1981:8), and when their numbers are added to those in common law relationships, they contribute to making the Caribbean an area with the

highest (35%) number of women-headed households in the Americas (UN 1995:5)

Postnatal women who do not live under the same roof with their bedmates are classified as "single" because of the absence of a visiting" category in medical (see Appendix B) and other official documents Based on recent census data, there is strong evidence to suggest that the number of female-headed households is growing in the Indian community in Trinidad This phenomena is correlated with the processes of modernization and industrialization in developing countries which have provided increased educational and occupational opportunities for women. Postnatal female-heads are in a position of disadvantage, after their puerperium, in that they do not have the help of an adult family member to care for their child The main source of emotional, physical and material support for single African mothers is the immediate community members in the "yard" (Brodber 1975, Henriques 1945). Coping strategies for these low-income women include support networks where grandmothers, kin, and neighbors are available to assist in child-care and child-rearing Female-heads of households with children have to perform triple roles as mothers, fathers, and breadwinners (see Safa 1995)

All researchers studying family organizations in the Caribbean concur that the extended family unit of Indians is unique As far back as the 1960s, Schwartz (1965) saw a trend moving from the extended to the nuclear families among Indians in Trinidad. He went on to itemize the main causes of the relative failure of the extended family system, one of which was intra-familial conflict situations (see also Nevadomsky 1983) While Schwartz may be theoretically correct, he is preposterous to announce the death of the extended family so soon. Though the high frequency of that type of family

form is no more, its spirit is very much alive today, and is expressed in the frequent networking among parents married children and grandchildren who often live in nuclear households located in the same vicinity. This frequency of contact in the rural as well as urban areas, has been facilitated by the access to telephones and the ease of vehicular transportation.

The intra-familial conflict, which Schwartz recognized, was started by a new generation of aggressive Indian women who had initiated a struggle for independence and authority within the family. Schwartz (1965:35) concedes that "[y]oung wives dislike being under the control of their mothers-in-law and press their husbands to break away." The experience of a masseuse whom I interviewed, who was living under the roof of her Indian immigrant in-laws in the 1940s, is symptomatic of fission that had started to appear in the extended family unit at that time. On her subordination, she reflects:

> For a daughter-in-law to live a life with India people is like knocking you head on a rock. You have to be a great devotee of God to survive. [It] is advantage. India people take advantage of other people children. But some was good, when ten good, one bad.

One of her chores as a daughter-in-law living in her husband's parents house was to massage her in-laws. She was also expected to perform other duties such as cooking three times per day for the entire family in keeping with traditional expectations. A row erupted between her husband and his parents about the abundance of work that she had to perform which led to the couple breaking away from the patrilocal extended residence. After she began "to turn my own pot."

It was a woman's struggle that today has blossomed into closer ties and contacts between married women and their mothers (see Nevadomsky 1983). This close relationship is strengthened when a child is born and the mother,

rather than the mother-in-law, is the chosen one to take care of the postnatal woman and her newborn. Based on personal observations of situations where all other variables are constant I have noted that working Indian mothers are more likely to leave their infants in the care of their own mothers than their mothers-in law. Grandparents, too, express more affection for their daughters than their son's children. An often whispered explanation for this behavior is "I know that my daughter child is her child, but I am not 100 percent sure that my daughter-in-law child is my son child."

Help/Health Seeking Behavior of Postnatal Women

I now examine how the various family forms in Trinidad act as a precipitating, predisposing, and contributing factor in the etiology, care and treatment postnatal women's illnesses and their newborn infants (see Litman 1979). I also discuss the family as a basic unit of interaction and transaction in health care. The type of family union plays a pivotal role in recognizing, diagnosing and deciding whether an illness should be treated at home, or by a professional source of care in the informal or formal health sector. Whether the family consists of the formal registered types, common-law unions, visiting relationships, neighborhood networks, nuclear or extended organizations, adult female members are involved in the decision-making process during the puerperium. Of course, the role the family plays in the process varies with the nature of the condition--i.e. whether the illness is recognized as acute, chronic or terminal.

I interviewed 64 women who were discharged from Mt. Hope Women's Hospital between June and September 1996. I asked them where

they went after discharge and who took care of them during the immediate postpartum period (Figure 4-4) Married Indian women (whether Hindu, Muslim or Christian) usually returned to their natal home if it were their first child and/or if their mother were alive and able to assist or supervise activities. About one-third (36%) of postnatal Indian women in the sub-sample (n=32) were in this situation. During the puerperium, their husbands would either move with them or stay in the nuclear household alone depending on how convenient it was to travel to work. Twenty-five percent (25%) of postnatal Indian women, who were living in virilocal joint families or extended households, did not return to their natal homes because there were no affines to care for them. In the extended or joint households, they had the assistance of their sisters-in-law and/or mothers-in-law

Indian women who had more than one child usually returned to their nuclear households, but had the assistance of a visiting female adult relative to perform household chores They comprised 19 percent of the sub-sample Fifteen percent (15%) of Indian women were already residing in their natal home (matrilocal residence) with their husbands, or in the vicinity and had the assistance of either their mothers and/or their female kin Postnatal single mothers (female heads of households) who were employed, basically took care of themselves with the help of neighbors. They often lived in rented apartments and were involved in common-law or visiting relationships This small (5%) group comprised Indian women who had conjugated inter-racially or inter-religiously, or were not on cordial terms with either their mothers or mothers-in-law

Since my previous calculations of the number of Indian women who have given birth to a child for a non-Indian man show that the figure is 18.4 percent, it seems that about half of them remained in their nuclear homes

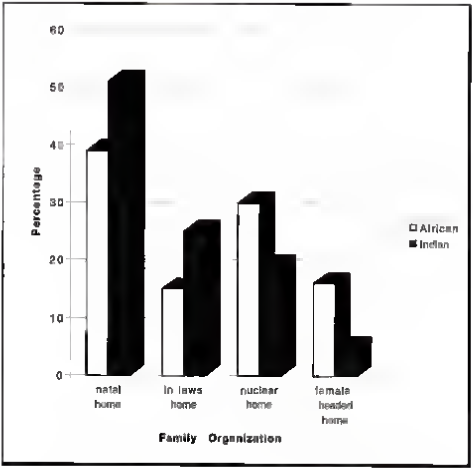


Figure 4-4 Where postnatal women went after hospital discharge (n=64)

during the confinement period thereby contributing substantially to the 19 percent category The phenomena of married Indian daughters residing in their parental home with husbands and children is on the increase in Trinidad Besides being revolutionary, according to patrilocal residential traditions, it reflects both the strengthening of the mother-daughter bond and the recognition of a female child as equal (if not more than) to a son especially in caring for their parents in old age

Compared to the 15 percent figure for Indians, 38 percent of African postnatal women spent their immediate postnatal period in their natal homes where they were already residing in the pre-pregnancy stage This group comprised women who were mainly involved in common-law or visiting relationships, and some teenage mothers as well.[13] Fifteen percent (15%) went to their natal home to rest during the puerperium When this figure (15%) is compared with the large (36%) proportion of new Indian mothers who return to their natal home where care is provided by mothers, sisters and masseuses, and the end of the postpartum is marked by a celebration with extended family members, it is significant It is this kind of extended kinship network support during illness among Indians in the Caribbean which moved LeFranc (1990:38) to note:

> The relatively low level of support and involvement is striking In Trinidad and Tobago, the level is somewhat higher--and this could be a reflection of the tighter family structure in the East Indian population. But, even there, assistance was largely confined to personal care

Fifteen percent (15%) of African postnatal women recuperated in the homes of in-laws compared to twenty-five percent of Indians Twenty-three percent (23%) returned to their nuclear households after hospital discharge (compared to 19% of Indians) Eight percent (8% vs. 5% of Indians) of them

returned to their single-headed households where they basically took care of themselves with the help of kinship and friendship networks The extra attention and social support given to postnatal woman in Trinidad precludes them from experiencing postpartum depression In all the cross-cultural situations outlined, however, men are noticeably absent from the network of individuals who assist during this period of confinement.

Much socialization of health and illness behavior (i e definition of signs and symptoms, patterns of utilization, health practices, etc.) is acquired within the family setting (Litman 1979) The presence of an older woman (the child s grandmother-type) in the family, as a source of health knowledge, is pivotal in the use of traditional medicine by the new mother Indeed, such an experienced authority as the primary agent of health-seeking behavior is absent in the nuclear family The sweeping social changes over the decades have drastically altered the role of elderly members of the family, and have shifted many health functions to non-family institutions In such situations, the role of grandmothers is often excluded or marginalized (UN 1996) I have found that contact between the grandmother and postnatal women is influential not only on the (frequency of) use of traditional medicine, but also use or disuse of modern medicine Like traditional masseuses, their beliefs and actions often function as a means of covert resistance against the knowledge of biomedical practitioners

The beliefs of elderly grandmothers are sometimes challenged by their very own adult children One 34-year-old Christian Indian women complained:

> These old people don t know why they do things They don t have any logical reason why they tell you to do things. They just do things because their old-time friend did it or their mother did it.

And the grandmothers responded

> These young people : when you tell them something they feel you don t know what you talking about

> These days children eh [don t] want to do what you tell them. They does say, [Do] you want to kill me?

Despite their misgivings, nearly all of the postnatal women comply, in one way or the other, with the instructions of their experienced elders They conform out of filiality and respect for their own mothers who insist on the value of traditional medicine for the new mothers future health Those who do not obey are warned that they would live to chastise themselves one day for foolishly disregarding the wisdom of "the old people" (see also Pillsbury 1978) Grandmothers function not only as consultants and providers of medicine but also as mediators between private, community and official modalities of treatment. The high rate of teenage pregnancy in the Caribbean has produced some grandmothers who are about 35 years old who are neither knowledgeable nor able to assume the traditional grandmother role (Senior 1991)

How do postnatal women in Trinidad select treatments among the various medical modalities which include self-medication, grand-mothers assistance, masseuses, priests, and doctors? I have found strong evidence to indicate that women move back and forth among various resources Their choice need not be exclusive, it may be complementary or alternative depending on the type of illness or the severity of the condition.[14] In my analysis, I use the term self-medication to include all treatments that were administered in the home without the advise/intervention of any consulting specialist. These treatments include herbal remedies, boiled water, special foods and pharmaceutical products Grandmother' treatment include all the

interventions recommended or administered by the child's grandmother or any older adult female in the community. Older family members, neighbors and friends are the most frequently mentioned interpersonal source of information in this classification (see also Litman 1979).

The masseuse category embraces all services which the masseuse provides, which consist mainly of massaging the new mother and the neonate, applying an abdominal band, and performing therapeutic rituals during the *chatti* (sixth day) ceremony. The priest label comprises the mainly spiritual services offered by men of the Hindu, Muslim, Roman Catholic, Adventists, Pentecostal and other religious denominations. The doctor classification includes advice and medication given by those of the biomedical profession which embraces nurses and pharmacists. The grandmother, masseuse and priest categories are symbolic of the system of traditional medicine. The doctor category represents the biomedical system, and the self-medication classification indicates the integration of the two major medical systems. These categories are constructed for convenience of analysis because there is some overlap. For example, nurses (in the doctor-category at Mt. Hope Women's Hospital) advise postnatal women to squeeze drops of breast milk in the eyes of the newborn to treat "sticky-eyes." Conversely, traditional masseuses use cotton swabs soaked in mentholated spirit to treat the newborn's umbilical cord.

Table 4-1 shows the distribution of first choice treatment modality for each of 24 conditions affecting 64 mother-infant dyads during the sixth week postpartum period. For problems relating to the breast and milk production, for example, 20 percent of women chose self-medication as a first choice of treatment. Thirty percent of them sought help from their grandmothers, 40 percent from masseuses, and 10 percent from doctors, and none from priests.

Table 4-1 First choice treatment modalities chosen for 23 conditions

Conditions	Treatment Modalities[1]				
	Self-medication	Grand-Mother	Masseuse	Priest	Doctor
Mother[2]					
pregnancy test	0	0	0	0	100[3]
breech pregnancy	0	0	20	0	80
after pains	60	0	20	0	20
breast (milk)	20	30	40	0	10
constipation	60	40	40	0	0
sitz bath	60	30	10	0	0
massage	0	20	80	0	0
abdominal band	10	20	70	0	0
herbal bath	0	30	70	0	0
herbal purge	0	30	70	0	0
stretch marks	70	10	10	0	0
Newborn					
jaundice	60	0	30	0	10
navel	10	30	60	0	0
sleeplessness	10	40	60	0	0
evil-eye	0	30	20	30	0
gripe	10	10	60	0	20
fontanelle	10	40	50	0	0
genitalia	10	30	60	0	0
dew	10	70	20	0	0
herbal bath	0	30	70	0	0
thrush	20	40	30	0	10
heat rash	20	30	40	0	10
bassuh	0	10	90	0	0

[1]Decision made after hospital discharge
[2]Not all mothers and newborns suffered from these conditions
[3]Figures rounded to the nearest ten, and calculated as a percentage

Generally informants chose the masseuse first for the treatment of abdominal problems, herbal purges, and almost every condition affecting the newborn The distribution analysis shows that it was only for pregnancy tests (100%), breech locations (90%), gripe (20%), afterpains (20%), jaundice (10%), breast(mulk) problems (10%), thrush (10%), and heats (10%) was the doctor chosen first Thus analysis masks inter-ethnic variability among women in terms of choice of treatments For example, culture-specific illnesses like *hassuli* (clavicle dislocation) are recognized mainly by Hindu women. Postnatal women also distinguish among the expertise of the various resource personnel available, they have different expectations from the four groups of help/health-care specialists (see also Morsy 1993)

Summary

Since the vast majority of patients in the public hospitals are either unemployed or low-income earners, they often have to tolerate the insensitive attitude of the nurses, as well as the doctors, at these institutions For this, and other reasons, most parturient women turn to traditional forms of medicine as a means of recourse to a more humane form of therapy In this chapter, I also discuss how geography, age, ethnicity, and educational attainment are correlated with fertility and mortality rates. I also show how ethnicity and family forms influence patterns of maternal and infant care The type of family organization plays a pivotal role in recognizing, diagnosing and deciding whether an illness should be treated at home or by a professional source of care in the informal or formal health sector The presence of an older woman (the child's grandmother-type) in the family

functions not only as consultants and providers of medicine, but also as mediators between private, community and official modalities of treatment

Notes

[1]During the educational sessions with in the district health, antenatal women are expect to be advised by the nurse or visiting nutritionists on matters relating to the postpartum care. My visits to three of the five health centers in St. George Central revealed that more emphasis is placed on labor and childbirth than on the postpartum period.

[2]One woman (Nanne 1995 9) wrote to the local newspaper to express "thanks and appreciation to the wonderful and very dedicated doctors" at Mt. Hope Women's Hospital and to say that "... the nurses were very nice" to her.

[3] Quiniou (1994 10) compares the hospital to an abattoir: "There were patients calling for nurses' assistance and the nurses would never come. They would remain wherever they were and shout back at the patients, in the middle of the night. What horrified me is those poor people who were in the ward. All night there were screaming, 'Lord, Father help me!' 'Mother help me!' 'Mother help me,' or 'Someone help me.' There were different people screaming. I've never seen nurses suck their teeth and shake their shoulders so much. Patients are now falling off to sleep and a nurse is walking along the ward with her shoes going 'Bang, bang, bang!'"

[4] The experience is similar to two (2) reports published in 1986 and 1994 in the local newspaper:
(1) "A baby was delivered when the mother laid in a helpless spread-eagled position with the baby between her legs for more than 20 minutes. The nurses were no where in sight said the adolescent mother. She reportedly informed the attending nurse that she was experiencing terrible pains. She also said, 'I can feel it coming.' ... The nurse held my belly and said it is not time yet. She said when the time is right my belly will get hard. The nurse then left me and went out of the ward." The Hospital Medical Chief of Staff denied any knowledge of the incident. He advised that a written report be submitted to him before he could take any action" (Danny 1986:3)
(2) "The mother of a stillbirth baby wrote, 'I am writing this letter to speak for all the poor people like myself who have to withstand the treatment that is meted out by the people who call themselves hospital workers. ... My water bag burst at 5 p.m. I was not even sure when it burst as all I saw was a dark

yellow fluid gushing out of me I called a nurse and she simply looked, nodded and left (Teenager 1994:9)

[5] Distressed Trinidadians do not have much faith in the efficiency and effectiveness of the complaints bureau which have recently been established in the public hospitals

[6] Other researchers (e.g. Burghart and Reissland 1989:51, Haire 1978:193) argue that episiotomies do not necessarily prevent severe lacerations in the perineum nor reduce fetal distress.

[7] About 560,000 women in the US undergo a hysterectomy annually a rate which is the highest in the world. Critics have complained that doctors are too quick to take out the uterus at the least sign of trouble, particularly with middle-aged women. They have also blamed greed by doctors and hospitals, pointing out that hysterectomies constitute a $3 billion-a-year business (Anger 1997)

[8] This term includes both late fetal and early neonatal deaths. Late fetal deaths are those that occur before or during delivery of fetuses weighing 1000 grams or more. Where birth weight is unavailable, the corresponding gestational age (28 weeks) or body length (35 cm crown-heel) should be used to define the cut-off point (Hogarth 1975)

[9] "A maternal death is defined as the death of a woman while pregnant or within 42 days of termination of pregnancy (irrespective of the duration and site of the pregnancy or its management but not from accidental or incidental causes" (WHO 1977:9)

[10] Fieldwork conducted in Trinidad by Clarke (1971) in 1964 reveals that Creole/non-Indian men who form unions with Indian women usually choose Christians. Hindu and Muslim men are more likely to marry out of religion than out of race, and they constitute the bastions of racial endogamy. Clarke and I, however, disagree on a number of issues relating to inter-ethnic sexual relationships.

[11] The fertility survey (WFS 1981:6) conducted in 1977 indicates that the proportion of married women of all racial groups was higher among the "less educated," which is the group that is over-represented at Mt Hope. But this factor cancels out the urban background of the patients which the survey found to be an element contributing to lower marriages rates. The researchers admit that the situation in Trinidad is a complex one in which ethnicity and age also interact with other variables.

[12] While Hindu widow remarriage in India has been discussed by social scientists, it remains a neglected topic in the Indian diaspora.

Hindu rituals and songs are still performed in the Caribbean with the assumption (mystification) that the bride is a virgin.

[13] Pulsipher (1993-61-62) notes that in the African low-income settlements ("yards"), children of teenage mothers are considered more as a progeny of the kin-group than of the biological mother . . . The widespread pattern of behavior as well as the consanguineal kin of young mothers indicate that there is acceptance of the idea that having babies is the explicit social reproductive role of a young girl.

[14] It is not at all surprising that Trinidad government analysts restrict their range of medical resources available to people to the biomedical sphere. A 1996 document on poverty levels (MSD 1996), for example, identifies pharmacies, doctors, hospitals and health centers as the only institutions providing health services in the country.

CHAPTER 5
TRADITIONAL MASSEUSES

When the cost of biomedicine is beyond the reach of low-income families, or when biomedicine is unable to cure certain (culture-specific) illnesses, home and/or traditional health care givers rise up to fill the void. The services they provide are comprehensive and include aspects of biomedicine as well as traditional medicine itself. In their practice, masseuses in Trinidad[1] represent varying degrees of traditionalism, acculturation and modernism (see also Cosminsky 1982). One reason why the work of masseuses persist to this day is their success in satisfying patients physical, mental, psychological, emotional, spiritual and social needs. The decrease in both the number of midwives/masseuses and the number of activities that they perform, however reflects the increasing secularization and penetration of Euro-American values transmitted through education, religion, television, etc. (see Miller 1994).

Profile of Traditional Masseuses

Traditional masseuses in Trinidad belong to the older group in the society (defined here as more than 60 years of age) who comprised eight percent of the total population in 1995 (UN 1995:25). Since this proportion of the population is expected to reach 9.8 percent by 2000 and 20.0 percent by 2025 (PAHO 1989:3), masseuses reflect an emerging demographic challenge to

public and private policy-makers concerned with the quality of life for elderly people in developing countries. In my snowball sample of 34 masseuses (excluding interns), all of them were over 50 years old (Figure 5-1). Twenty-five percent of them were in the 50 to 59 age group, 33 percent were between 60-69, 29 percent between 70-79, eight percent were between 80-89, and four percent were over 90 years old. It is true that the older they are, the more they are sought because their reputation as practitioners of traditional medicine depends on the amount of time they have been active. Whether due to lack of available data, or the apathy of a large number of researchers, elderly women in the Caribbean are often treated as invisible members of the older population, and appendages to their husbands (see Sennott-Miller 1989). In this chapter, it is my objective to show that the role of masseuses in dealing women's and children's illnesses have empowered them to become workers rather than dependents, producers rather consumers, and caregivers rather than care recipients.

Of the 34 masseuses I interviewed during the summers of 1994, 1995 and 1996, only four (12%) were non-Indians, mainly Africans. The vast majority (88%) were Indian women of the Hindu religious denomination. Non-Indian masseuses were as popular as their Indian counterparts even among Hindu clientele. Ethnicity, therefore, is an important variable in the profession of massaging, and it influences the therapeutic regimen significantly (see also Sargeant 1982). One basic difference between the African (or Spanish) and Indian massaging therapeutic repertoire is the use of prayers and rituals which accompany the healing process. In this respect, non-Indian masseuses have become quite "Indianized" in their adoption of Indian cultural traditions.[2] This acculturation has expressed itself in the use of Hindi lexical items, devotion to Hindu deities, the employment of Indian ritual

Figure 5-1 Family of masseuses Sixty-six year old Samdai (left) stands next to her sister, Somari, 75 Intern Kamla 42, is next to her mother

paraphernalia belief in Indian cultural-specific types of illnesses, and the appropriation of a Hindu world view of health and healing With respect to the technique of massaging itself non-Indian masseuses identify the Indian method of massaging with the soles of the feet as a practice not typically African Hindu parturient women who procure the services of African masseuses do so out of the belief thet these healers have more potent prayers, superior knowledge of medicinal herbs, and better skilled in the art of folk obstetrics and gynecology Hindu masseuses are sought more for performance of Hindu rituals than the bodily manipulation itself which compliments the massage Hindu masseuses who treat Christian and Muslim women, avoid hurting their religious sensibilities by aborting the ritual aspects of their (masseuses) healing repertoire.

In keeping with national statistical trends, education shows the well-established, yet striking inverse relationship with the age of masseuses Educational attainment is substantially lower among the oldest age groups with very few of the oldest women completing education beyond primary school. Masseuses 65 years and older could neither read nor write English, though most of them were bilingual in English and Hindi. They had little formal schooling and had never consulted any book on the subject of human biology, not to mention obstetrics and gynecology Generally, the African masseuses went to school for a longer period than their Indian counterparts Up to the 1950s, Indian girls were discriminated against in favor of boys in access to education. ("They say if you send the girls to school, they would learn to write letters to boys") Indian girls were sent to elementary school for a period of three to four years, and were then kept home to perform domestic duties while both parents went to work in the fields. To this day, even in their new role as grandmothers, some of them still feel caught in the never-

ending reproductive spiral of housework and childcare One 60-year old grandmother who lives with her married daughter and her family complained

> I tied up in the house I can't get away to learn anything When I small, I mind my brothers and sisters. I see plenty children in my young days When I married I make seven children I see real trouble to send my children to school, for food for clothes every every thing And after, I stay here to mind grandchildren. I never free

On the evening of the interview her daughter had gone with her husband to the tomato field, and had left her to housekeep and baby-sit.

Like traditional midwives in Guatemala in the 1960s (Paul and Paul 1975), Trinidad masseuses are usually poor and widowed, and sprung from a pool of older women who are no longer tied to child-rearing routines Of the 34 masseuses I interviewed, 24 (71%) were widows, which is not unexpected when one considers that women in Trinidad outlive men by five years Husbands who were separated were usually remarried, and were counted by their former wives as dead. National gerontological data (PAHO 1989) for 1987 show that among women in 60-64 age group, 27 percent were widowed compared to 14 percent of men of comparable age. In the 80-plus category, 59 percent of women and 27 percent of men were widowed In my sample, 55 percent of them were living in an extended family with a married daughter while 30 percent were living with a married son. Studies elsewhere (e g. Sanchez-Ayéndez 1993) also indicate that daughters, rather than daughters-in-law, are the primary support providers for the elderly [3] In my sample 12 percent of masseuses were living as a nominal female head of a household with a bachelor or single son, or a spinster or single daughter Their status in the household was "nominal" because at least another adult member was making a greater financial contribution to the family's purse. However full-

time masseuses (21%) were providing a greater share of the household's income. Masseuses in general represent a vulnerable group in the society because they are poor, elderly, and female.

Training of Masseuses

There is no kind of formal training in Trinidad to become or to increase the knowledge of, a traditional masseuse as is the case with a traditional Indian midwive in Guatemala who receives an official license after completing a course (Cosminsky 1982). Almost all the 34 masseuses I interviewed acquired their knowledge and skill from a close family member who was usually an elder *dhagrin* [midwife] herself (see also Hart 1978, Perrone *et al* 1989, Sergeant 1982). Twenty-eight (83%) were taught by either their own *dhagrin* mother, *aaji* [maternal grandmother] and/or mother-in-law who would take them along during house calls. ("We follow them all about until we take up the trade"). Their knowledge of "rubbing" was supplemented by observation of other midwives' practice in the village and, sometimes, by observation of their own fathers' work as a "massage man" [masseur/bonesetter]. From family models, masseuses learnt how to recognize and treat many women and childhood complaints including culture-specific bodily dislocations like *kassuli*, *nara*, and *boochet*. Their period of observation, training and internship varied widely from a few months to several years. Some of the masseuses were attended to by their own *dhagrin* mothers during labor, childbirth and the puerperium.

Nearly all the masseuses were exposed to the profession even as a child growing up in a family of healers. One masseuse recounted how, as an eight year-old girl in 1929 who "had a little sense," she witnessed women with

children visiting her *dhagrin aaji*. The whole village coming by *aaji*. Every evening, *aaji* attending to people like a doctor." Young girls would sometimes stay with their masseuse-mothers at the home of postnatal women for the full twelve days of confinement. Masseuses own careers in massaging infants often began when they themselves began to rub their own children which, during their generation, numbered as many as eleven (*sv*=7). Indeed, the daily ritual of massaging the newborn is an Indian family tradition, which the Indian masseuse, as a child, would surely have had experienced. The profession came to Trinidad with the immigration of indentured laborers from India. It was passed down to successive generations of women running from grandmothers to mothers to daughters, but tied to the low class and *baniya/chamar/dhobi* caste of the Hindu community. This social and cultural trait/tradition was invisible to the anthrocentric eyes of Schwartz (1965) who studied the remnants of the caste system in Trinidad. As is the case in India (Cosminsky 1976, Mayo 1927), the profession is still today held in low esteem by the male-dominated society due to beliefs regarding impurity and pollution. All the masseuse who were conscious of their caste origins challenged and negated this stigma. One attempted to assert pride in her identity as a woman, and as a former *chamine* [midwife]:

> I is the real *chamar*, the person who does do maidy work. This is the only nation [caste] that does cut navel string. The people of the *chamar* caste is great; without them no one could be born.

Many of the masseuses were compelled to massage their mothers-in-law, fathers-in-law, and/or husbands after marriage in keeping with traditional expectations of the Indian extended family. Their fathers-in-law had to be massaged first because he wanted to retire early to bed after a hard

day's work in the fields. One masseuse recounted how she had to massage her mother-in-law nightly, in addition to performing other household duties:

> My father-in-law used to say: 'Go *dulahin* [daughter in law] Go to sleep.' One day he quarrel with me mother in law. He say: 'The child does do so much work, cleaning all over the place, and you don't feel sorry?'

Another masseuse related a strikingly similar experience as a young daughter-in-law in virilocal residence in Trinidad in the 1950s and 60s.

> I had to rub me father-in-law, me mother-in-law, and me husband three time a day. I had to rub me father in law back, he two foot. How much strength [did] I have? He was to do *pandit* [priestly] work. And then, I had to wash a tub of clothes and cook lunch. I had to clean the house and the place [was] big!

Her subordination was compounded by the fact that she was of a caste lower than the priestly *brahmins*. She complained that, as a daughter-in-law and as a wife in the household, nobody ever considered giving her a massage because it was perceived that she was not doing any 'hard work' in the house. Yet she had to work as if she were "crazy," rising from bed as early as three in the morning and retiring at ten in the night.

The experiences of most of the masseuses were similar and included recollections of being tired yet having to massage their mothers-in-law in particular. 'Sometimes I drop asleep on she belly. She would never tell me, 'That [is] enough. You [are] tired. Go and take a sleep.'" Up to the 1960s in Trinidad, Indian women in general suffered because of social, cultural, political and economic gender discrimination.[4] Part of the suffering came from having to massage multiple generations of people, besides having to do housework and childcare. This life-long misery is succinctly expressed by a 66-year old rural masseuse:

> I seeing trouble from the day I born – In me mother house I had pressure In me mother in law house, I had pressure In me own house, I had pressure with me children And now in my old days, I have pressure with me grandchildren.

While under the roofs of their fathers-in-law, some masseuses began their practice of treating village women and children Their mothers-in-law found diversion and pleasure in "blaging" [chatting] with visiting female patients. They now lived leisurely lives because they had delegated all housework to their *dulahins* 'Food and water [were] meeting them right there in the bench where they sitting down whole day.'

Only four (12%) of the 34 masseuses interviewed had a student learning the techniques of the profession. These interns were all daughters of the masseuses who were unemployed, sometimes married, middle-aged, and lived in the same house or close to their mothers (see also Sergeant 1982). They encouraged their daughters to learn the techniques of bodily manipulations so that they can, at least, earn an income in difficult times ("This work will always put a bread in you hand' and "you will never be out of change [coins]"). The amount of payment may vary but at least there would be an offering of appreciation in one form or the other When there are too many patients in the waiting area, masseuses allow their interns to treat the less complicated problems. They may be even sent on house calls by themselves One advantage in having an intern in the masseuse's house is that patients are not turned away because 'the lady who does rub is not at home."

Interns who are ambitious augment their knowledge of healing by looking at television documentaries on health, and by reading books on local remedies Their modes of treatment, therefore, differ from that of the elderly masseuses, for example, while the intern recommends an over-the-counter

medication called 'Kaopectate' for diarrhea, the elder healer would prescribe an ingestion of dough pills made by mixing unparched ('raw') flour sprinkled with water. Daughters of masseuses who do not want to serve the public apply their knowledge only to members of their immediate family, particularly newborn infants. Strangers do not seem to be interested in learning, and even if they do, masseuses are not too anxious to reveal their knowledge, which they claim was granted to them by a divine spirit. They do not really fear the threat of a young stranger who may emerge as a possible competitor or eventual replacement because they have age and experience on their side (see also Perrone *et al.* 1989). Generally, young women are not inclined to become masseuses because the work is not considered as "real work," it is irregular, it involves complex herbal and ritual knowledge, and is stigmatized as a low kind of domestic activity.

All of the 34 masseuses I interviewed claimed that they feel that the hand of God guides them in manipulating patients' sick bodies. Africans and Indians alike avow that they have a "good" therapeutic hand which is a "gift" from God rather than from their ancestors (cf. Green 1989:198; Perrone *et al.* 1989:107). They say they sense a benevolent spirit assisting them as they knead, push, pull and press the ailing parts of the patient's body. One 77-year old masseuse invoked religious images in talking about her interaction with her patients:

> By the help of God, if anybody come[s] here and they tell me they can't walk, or something happen to them I does try to help them. I does take me time with me hand you know. I don't rush. I like to see what I doing. By the help ah God, they does get good, and they gone. They does go happy, and they does bless me too.

Another masseuse recalls patients' satisfactory responses to her "good" hand: "As soon as I rest my hand on them, they say, 'This is a different hand.'"

Indeed, when they *jharay* [ritual healing], they must summon the aid of Hindu deities with *mantras* [sacred formulae] which they must recite while fasting. None of them claim however that they intuitively learnt their skills from divine intervention, dreams, or meditation (cf. Cosminsky 1982). They identify the hands of other healers as either positively "light" or negatively "heavy." For example, a doctor or nurse may have a "light" hand if he/she administers an injection which does not hurt. Conversely, a dentist who causes pain to a patient during a tooth extraction is believed to have a "heavy" hand.

Traditional masseuses in Trinidad do not wear any identifying clothes or symbols like biomedical practitioners (cf. Gelfand 1985). They do not announce their services by the conventional forms of advertising. Their practice both in the domestic sphere and the public domain, therefore, make them identifiable and invisible at the same time. It is only through family, village, and client networks that the society recognizes their knowledge. Family members, village women and patients spread the word when they encounter someone who is suffering from a complaint that can be treated by the masseuse ("This one telling that one; thet one telling the other, and so the thing going"). In the same district where the masseuse lives, women advise anxious mothers to visit her ("Go Look Leela mother could rub"). Strangers appear at their doorsteps pleading, "The child crying, crying. See what you could do for me nuh [please] I try the doctor and [it] is the same thing."

One widow and pensioner, who was the only masseuse to gain recognition without a family reputation, recalled how she started her career. She used to massage her *bhowji* [father brother's wife] from the 1940s since she was eight years old when she was adopted as an orphan. Her *bhowji* told

the neighbors that Daha massaged with skill similar to that of Ramkaliya, the village maidy' [midwife] and masseuse who was from India. Word ran throughout the village When Daha went to fetch water from the well she met the village women on her way who would ask her for a massage Soon they were expressing their approval by announcing to others, "She come out just like Ramkaliya She rubbing just like Ramkaliya." The society that recognizes a masseuse also has the power to disenfranchise her through the same oral network.

Activity Levels of Masseuses

Based on my research during the summers of 1994, 1995 and 1996, I have roughly calculated that there are 4,386 active masseuses in Trinidad.[5] It is expected that more of them practice in the rural Indian areas where they perform other paid activities during the day (see also Gelfand *et al.* 1985) This means that there are certainly more masseuses than medical practitioners in the rural areas, but more full-time masseuses in the towns Of the four African masseuses I found, all were full-time practitioners who were living in Indian-dominated districts. They cross religious and racial boundaries, and make use of the cultural heterogeneity present in the multi-ethnic Trinidadian society The majority of patients of part-time masseuses come from the district in which the masseuse lives or an adjacent village Full-time masseuses travel widely and their clientele are spread over larger geographical areas. Indian women form the bulk of clients of masseuses of all types, they argue that they procure the services of a masseuse based on her expertise and not on racial or ethnic consideration

In my sample (n=34), only about a quarter (21%) practiced full-time which means that they gave this income-generating activity preference over domestic and household duties. Full-time masseuses were more likely to be available to patients who need their services at short notice, during house-calls, and at any time or day. They visit the homes of new mothers twice daily until the sixth day postpartum. These masseuses have passed their child-bearing years and do not have the responsibility of taking care of a husband or young child (see also Paul and Paul 1975). The number of patients they serve in a week varies over a wide distribution ranging from four mother-infant dyads to treating three adult women. Full-time masseuses set aside a private room with a bed at home where they diagnose and treat patients. Since women rarely visit alone, wooden benches are placed in an open shed where their companions can sit and wait. One masseuse was so conscious of her poverty-stricken state that she prefered to visit patients at their homes rather than allowing them to see her dilapidated, unpainted, wooden, one-room shack.

Part time masseuses earn an income from other regular sources, like domestic work, sewing, gardening, or the government's old-age pension or "poor relief". It is the uncertainty of the job market which, in part, prevents them from pursuing a full-time career. They realize, too, that women are no longer bearing many children, traditional culture-specific beliefs are on the decline, patients' payments do not always satisfy their expectations, and an increasing number of people are depending on modern medicine. Moreover low-income families cannot always afford to secure their services for all of the six days postpartum. Sometimes, they are called only on the sixth day to perform the ritual bath and to officiate at the *chatti* [sixth-day] ceremony.

Part time masseuses, who are confined only to housework and (grand)childcare, attend to visiting patients on evenings and weekends when they are free Those who bear the double burden of housework and "outside work have very little time to serve others, as this 63-year old laborer reveals

> I eh [not] lying to tell you Sometimes I used to get vex, to tell you the truth I come home tired. I say to meself, "Just now is five o clock and I have to prepare dinner Then I have to prepare for all the children to go to work in the morning And thus is the time these people would come? But my husband used to say, 'Go, hear what the people have to say and help them."

Except for his supportive words there is no evidence that her husband shared the housework while she was "helping" others If masseuses are unable to treat a visiting woman because of the demands of housework or illness they refer her to another folk medical specialist in the district.

The old masseuses complain that their weak physical condition is an obstacle to performing their duties. Most of them suffer from arthritis which they believe is the result of hard work endured during their youth In the homes of their parents as well as their in laws, they had to carry bundles of grass on their heads for cattle-feed, water from the well for household use, and stacks of dried sticks for the fireside In the sugarcane fields, they cut cane and "break" banks Masseuses over 60 years old believe that age has decreased their strength to perform certain bodily manipulations "Long time I used to rub better I used to handle hefty man and twist them and they used to bawl. Those who cannot travel by themselves, without an able companion, go on distant house calls only if a vehicle is sent for them and they have been assured that it will return them home The very elderly masseuses, who performed the role of midwives in the past, are relieved that hospitals have now taken the responsibility of the birthing process The double burden of

house work and public work was exhaustive and too much to bear. They recalled, "I never get chance/time for meself," and "Sometimes I didn't get rest."

Payment for Treatment

Full-time masseuses in Trinidad choose their career path with the knowledge that it would not provide them with a steady income, but at least it would give them self-esteem, community recognition, and freedom from male dominance and dependence. Since full time masseuses use their profession to derive their main source of income, they charge a fixed fee for their services. The average fee charged for six days of services during the puerperium is US $34, which is twice the amount that would be paid to a domestic servant for the same period. The home-service the masseuse provides, includes daily tasks of massaging both mother and infant, the concoction and administration of herbal medicine, the application of abdominal bands, assistance with the sixth-day bath, and the performance of rituals during the celebratory *chhati* ceremony. Their objective is to bring both mother and child "up to mark."[6] Before the 1950s when most women had home-deliveries, full-time midwives/masseuses were considerably more in number and some of them were able to save enough money to buy a plot of land, build a house, purchase cows, or even shoulder the expense of their children's weddings.

Part-time masseuses do not request a specific sum of money for their services, but they expect their clients to donate US $2 to $4 for a visit in a country where the average daily wage in 1993 was US $10. (ILO 1995:106). The masseuse' fee is relatively small compared to the average fee of the family

doctor which is US $10. One 60-year poor old widow said that village patients should realize that she does not have a husband to support her anymore and should, therefore, compensate her financially. After the oil boom in the late 1970s masseuses intensified their requests for cash payment in keeping with the convention of doctors who charge their patients a fee for treatment. Most part-time masseuses do not request any payment for "rubbing" an infant.

All of the masseuses interviewed (n=34) expect their patients to acknowledge them for their services in one form or the other (see also Rocha 1991, Sergeant 1982). Even part-time masseuses feel disappointed when a villager, whom they had "rubbed" the other day, walk by the following evening without uttering a greeting. Masseuses receive gifts (especially cloth for dress-making) during the Christmas season from satisfied patients and from those who had gone overseas. Indicators of gratitude for services rendered, therefore, do not necessarily have to take the form of monetary compensation. Chandai, a widow-masseuse, recounted an incident when she responded to an emergency house-call on her way home from a wedding ceremony. A woman was experiencing severe abdominal pain even after a visit to her physician. ("The big, fat, strapped lady could not even get up from the bed"). Her husband could not understand the cause of the pain or the severity of it, and was frantic. He pleaded to the masseuse: 'See what you could do for me, *didi* [elder sister].' Chandai requested oil which she used to massage and 'crack" the woman. She felt better instantly. When Chandai was finished, she told the couple that she was leaving, and they replied, "All right." Chandai was disappointed that they did not offer kind of tangible compensation, not even a drink of water or whisky of which there was plenty on a table because there was a drinking party in progress. Chandai thought

that the couple was "well *nemackaram*" [ungrateful] and vowed to buy herself a drink of rum on her way home.

Full-time masseuses volunteer their services to extremely low-income women and children with the explanation that, "You can't always take, you have to give sometimes." Seventy percent of all the mainly Hindu masseuses interviewed confessed that they perform selfless service to patients whether they intend to pay them or not (see also Doughty 1978). They feel obligated to god, who has granted them a divine gift, to heal the sick and ailing. One masseuse feels compelled to use her hand which, she believes, is guided by God without lifting it in anticipation of payment:

> I must do what God tell me to do. He give me the idea and I have to do it. They could pay me or eh [not] pay me. I going to do it.

The main motivation for serving their poverty-stricken patients is *dharma* [religious duty]. A masseuse said she would continue to volunteer her services until she retires from her full-time job as a monthly-paid laborer with the government-owned sugarcane estate ("Some ah the people I does help out does bring big money and drop it in me lap and I doesn't take it.").

Another masseuse recalls that in the 1930s her *ajaa* [maternal grandfather] used to reprimand her *atti* [maternal grandmother] for requesting, or receiving, payment because he was convinced that her skill was divinely inspired. "You want people to pay when you get this thing [gift], you did pay for it?" He was also concerned about the distressed condition of most of her adult female patients:

> You don't know if the lady' child want something to eat, and he must be hungry, and she ha' to give that money to you instead. Let the lady feed the child with it. When you doing good, do good right through.

But her *ajii* was in need of money which her *ajaa* was not able to satisfy. And so her patients would secretly offer *ajii* a few pennies which she would hide in her dress-pocket to buy chewing tobacco. In *ajii's* era, if patients felt the need to reciprocate, they gave token payments discreetly after the illness was cured, which may sometimes be weeks after the visit. Masseuses today can often identify village patients who are genuinely poor with whom they extend sympathy. Some of their patients confess that they do not have the capacity to pay. After being massaged they say, "Gryul, I eh [do not] have money, but thanks very much." And the masseuse, who is often poor herself, replies, "That eh [is not] nothing. All ah we is poor people" (see also Mayo 1927). Masseuses note that wealthy families are often stingy to pay. "Those who have money, they crying more than me and you." In their minds, these folk practitioners ask a common question. Wouldn't these rich people have to find the money somewhere if they had visited a doctor?

Some part-time masseuses leave the decision of how much to pay to the conscience of their patient or their patient's companion (see also Cooper 1993). They all told me, "Anything they give me, I satisfy with it." After some patients are treated, they say, "Thanks very much" and leave without offering any kind of token monetary compensation even for the oil that was used to massage their skin. One widow-masseuse and household head said that if patients were compelled under convention to reward folk medical practitioners for their services, she would have taken her profession more seriously, and would have offered her services on a regular basis. She explained that one masseuse in the village was able to volunteer her services because "sha have a big house, she have plenty land and plenty money." Another Indian masseuse related how she was once suffering from a chest pain and decided to seek the treatment of an African masseuse in the village.

She paid her US $1 00 for her service though the masseuse did not request a fee. She paid because she had understanding,' and because she had dignity and self-respect as an adult (" a big person') She discussed fee remuneration with her colleague who said that she does not accost any patient about payment. If they do not pay, she allows them to leave, but not before she curses them in her mind, saying 'You go spend more than that [elsewhere without satisfaction] '

The adult children and grandchildren of volunteer masseuses are not pleased about their non-compensatory work. They strongly advise their grand/mothers to "tell them flat that they have to pay ' Masseuses are also advised that if they suspect or know that a certain patient would not pay, than they should make an excuse about their poor health Or the masseuses should say that they are busy and refer their visiting patients to another masseuse in the village To turn away an acutely ill adult or a sick child under such circumstances, however, is unthinkable Part-time masseuse find it difficult to accost a non-paying patient, they say they can neither lower their self-respect nor make their hearts hard to demand a fee payment.

Relations with Others

The attitude of living sexual partners of the masseuses toward their profession was investigated to draw conclusions on gender issues in the private and public domains. Most of the masseuses (65%) disclosed that their husbands were either neutral or supportive of their work in treating patients who visited their homes, once they had completed all their domestic duties. (He never used to quarrel") There is ample evidence to indicate that while they felt "sorry" for the visiting sick people, they were not sympathetic to

their over-worked wives. A widow recalled how her deceased husband was opposed to her profession in the 1950s and 60s and used fear of the law as a reason to discourage her since she was practicing without a license. He had threatened to evict her from his house, saying:

> *Mai* [mother] you better go by you son and play doctor I eh [do not] want no police to come here If police come for you I will put you out of the house and you can t come back again

She defended her profession by stating that she practiced secretly in her own house and that even off-duty police officers visited her for treatment To avoid conflict with her husband and to fulfill her desire to serve people in pain ("I like to go and help people out"), she devised a strategy to deal with the problem When her husband was home she secretly told visiting patients to return when he had gone out to work

Even when all the housework was satisfactorily completed, some husbands (and parents-in-law) insisted that their wives remain within their suspicious eyesight. African masseuses also had to devise strategies to resist their partners control. They had to provide specific information on where they were going, what they were going to do, how long would they be out, and how much they will be paid, before they got permission to leave the house. African men in Trinidad were socialized in the Indian/Hindu belief that midwifery and massaging were "dirty" work. This control of men over women prevented many masseuses from responding to house-calls and becoming full-time practitioners (see also Paul and Paul 1975) Generally it is only when their husbands die, migrate, separate, or become bed-ridden, that masseuses become free to practice their profession.

All the Hindu masseuses have other skills which they contribute, often voluntarily, to the community The more adept are commissioned for three

days to prepare ritual paraphernalia and perform some of the rituals ("do *naw* work") during Hindu ceremonies. During *chattis* [birth celebrations], weddings and other social occasions, they participate in singing Hindi songs on stage. Lead singers are called upon to render solo *bhajans* [Hindu hymns] by the officiating *pandit* [priest] during readings of the Hindu epic poem, *The Ramayana* in which as many as 1,000 people attend. Masseuses are recognized in the district in which they live and work, and younger folks refer to them respectfully as "Granny," "Tanty," Tanty M___ ," "Didi" [elder sister], 'Mousi" [mother's elder sister], and 'Nani" [maternal grandmother]. But masseuses derive the deepest satisfaction from their main profession. One African former midwife related how children sometimes meet her in the street, asking, 'Do you know me?' When she responds in the negative, they reveal to her delight, "And you brung ma in the world." African masseuses, however, are precluded from participating in anything considered sacred/religious (like the cooking of *prasad*, for example) because of the Hindu sense of pollution.

Only nine percent (9%) of these elderly masseuses continue to sew clothes on a commercial basis at home. They also apply their expertise in making decorative ornaments for elaborate Hindu ceremonies. Those who are able, cook *roti* [unleavened bread] and *talkari* [curried vegetables] for hundreds of guests. The more destitute masseuses wash cooking utensils ("wares") during Indian gatherings, and do the dirty laundry of the postnatal household. They perform these domestic chores to make a little change [money] to keep life going." One Indian masseuse recalled that as a child in the 1930s, she would accompany her mother on her home-visits when she went to do "maidy work." She would assist in fetching water from the well, hanging washed linen to dry in the sun, scrubbing the wooden steps of the

house, sweeping the floor and yard and *leepaying* [plastering] the dirt floor with *gobar* [cow's dung]. A 90-year old masseuse recalled that she used to wash the stained "bedding" with her feet and rinse them with her hands so that her hand would "remain clean." The washing of white cotton diapers have now become obsolete because of the availability of disposable diapers and linen. Washing blood-stained clothes of non-family members is considered "nasty work" by the society in general, and it is this task which signifies that the profession is characteristic of the low *chamar* caste. Assisting with household chores, however, was part of the postpartum support system that included social, ritual and psychological components as well (see also Cosminsky 1982).

There is no evidence to suggest that masseuses worked together as a team, or that they made an attempt to form a professional body. The decreasing number of cases that they treat have made the job competitive. They, therefore, seldom make complimentary remarks about their colleagues, citing monetary greed as a reason for their dismissal. In comparing herself to her village counterpart, one masseuse said:

> I does put more labor. I don't want somebody money who doesn't satisfy. I must sweat for it. When they ask me how much I will charge, I say, 'Is according to how much you satisfy.' Whether you give me $20 or $15 or $10, I will take it in the name of the Lord. I wouldn't cry. Whatever you give me, give ma with a clear conscience.

Another disclosed that her colleague ("the fat lady") was very selfish, and recalled that it was only once that she had referred a patient to her because she was very busy. They also argue that while some masseuses claim to be adept in their profession, they hurt ("damage") some of their patients. All Indian masseuses have respect for knowledge of herbal medications (bush

medicine") which they believe is vested with the elderly Spanish masseuses whom they sanction to be the most skilled in the profession.

Though they refer some of their patients to doctors, masseuses in Trinidad question the humanness and motives of those who are engaged in the biomedical healthcare industry ("Doctors will eat every cent of your money if they get a chance") They claim that while doctors are trained to treat diseases, there are definitely some culture-specific types of illness which they cannot cure (see also Perrone *et al.* 1989) Doctors seldom refer their patients to a masseuse of other traditional healer as an alternative source of help They merely tolerate their healing rituals at the bedside of their hospitalized patients because these are deemed as non-invasive and religious practices One masseuse questioned doctor's rejection of "bush medicine" and postpartum abdominal band when these therapeutic measures were in existence from the time of creation. Masseuses feel that traditional forms of healing are of, for, and by the people and not a profession that has to be learnt in foreign medical schools They condemn the physician's readiness to prescribe a pill or administer an injection for musculoskeletal problem instead of recommending a massage. Masseuses argue that people should ultimately be blamed for the exploitation by doctors because they should learn to prevent, recognize and treat some of the complaints themselves

> Nowadays parents don't know when they children have *najar* [the evil eye] As soon as they start to cry, the mother running to the doctor But what the doctor would do? The doctor will ask YOU what is the problem? The doctor don't know

The Trinidadian public shares some of the sentiments expressed by traditional masseuses During the 1996 industrial strike for increased salaries, for example, many people were not sympathetic with the doctors whose

actions, they suspected, were driven by "mercenary" motives They felt that, "They like too much money and they do not care about patients (Hernandez 1996 12)

Types of Conditions Treated

Hospitals in Trinidad have usurped most of the traditional functions of midwives who were, until the 1950s, very active in attending to parturient women and their newborn. Their services have been truncated to rubbing the new mother and her newborn, and performing rituals to placate the supernatural spirits. They still, therefore, reaffirm an important link between this world and the other, natural/traditional medicine and "doctor medicine." In addition, they *jhuray najar* [cure the evil-eye], deal with neonatal jaundice, treat culture-specific bodily dislocations like *hassuh* among infants, *boochet*, *nava*, and *pulai* Most of their therapeutic treatments are related to attempts to relocate bodily organs which are believed to have been shifted from their normal positions (see also Foster 1953) Traditional masseuses primarily treat non-life threatening conditions, and often refer their patients to doctors when the feel thet curing a complaint is beyond their expertise.

Female Infertility

Trinidad masseuses boast how they have successfully treated women who felt thet they were infertile for as long as ten years They claim that doctors *are* often amazed at the positive results of their cures but have never tried to contact them It is mainly this specialty that attracts non-Indian

women to them Masseuses believe that female infertility is caused when a woman's womb or "mattress" is "out of place" or "too low" which has to be corrected by inserting the fingers into the vagina and pushing the uterus up This dislocation is believed to be commonly caused by lifting heavy objects. Infertility may also be the result of improper abortion by doctors as well as backyard female practitioners Infertility is also believed to be the result of "cold" accumulated in the womb which, along with other 'nastiness,' has to be cleaned out. The problem of infertility has to be "fixed" by a masseuse by means of abdominal massage, cupping [discussed later in this section], and other procedures, rather than through surgery by a gynecologist. They admit that, at times, their treatment regimens fail because it is "sometimes God' work that some women can't have a baby."

To treat the problem of female infertility, they make a concoction the ingredients and administration of which vary with the ethnicity of the masseuse African masseuse use an old Spanish-derived medicine which consists of a brew made of honey, aloes and egg albumin. This mixture is drunk, and is followed by a combined purge of honey, castor oil, lamp oil, olive oil and boiled ginger An adhesive plaster is placed on the woman's back. The plaster contains a paste which consists of brandy, egg albumin, flour and vinegar If the masseuse believes that the problem is caused by inflammation in the tubes, wild coffee roots are collected, washed, pounded and boiled, and a purge is administered

Indian masseuses, on the other hand, make a fertility "plug" consisting of ingredients familiar to their kitchen, household and garden environment These include jawine, a raw grain of *channa* [chick pea], a dried ground *ganja* [marijuana] leaf, ground ginger, and a block of camphor which is optional. Some masseuses add harjor and allum. These are wrapped in a piece of clean

cotton *dhoti* [loin] cloth and tied into a bunch "like a ball." The ends of the sewing thread are cut long like that of the IUD contraceptive. The bunch is dipped into a glass of white puncheon rum, lubricated with petroleum jelly, and inserted into the vagina of the patient where it is left until the "mattress" is "set." During this period of treatment, the woman is advised not to engage in sexual or vigorous activity. When the 'mattress' moves into its natural place, the muscles of the vaginal opening is expected to expel the "plug." If not discharged after three days, the fingers of the masseuse would have to extract it.

Pregnancy and Pre-natal Sex Tests

Masseuses also claim that they can perform pregnancy tests from as early as three months by touching the abdomen and feeling "a beat." If the pregnancy is four months gone, the expectant mother can feel the heart-beat under her abdomen herself while sitting. A "lump" can also be felt. The doctors (n=30) I interviewed maintain that, around the fourth month of pregnancy, they can hear the fetal heart beat without the use of instruments. Masseuses in Trinidad also claim that they can determine the sex of a baby by observing the shape of a woman' swollen abdomen. There is general agreement that if it is a boy, the abdomen would be protruding ("long"), if it a girl, it would be round ("spread out")

Assistance with Deliveries

The law in Trinidad now mandates that women should deliver their babies at clinics or hospitals. But before the 1960s when health facilities were

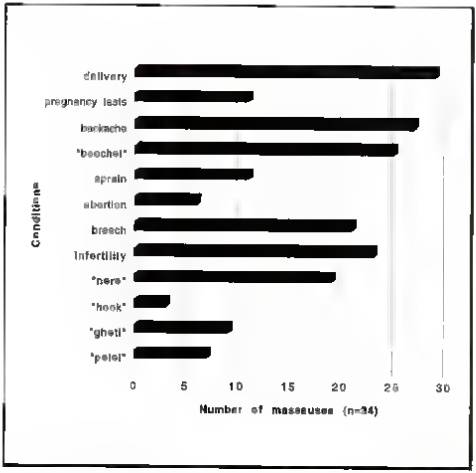
not so readily available, traditional midwives/masseuses attended to deliveries at home ("put ladies to bed").[8] They prepared for deliveries by boiling a pot of water, sterilizing a pair of scissors, cutting pieces of sewing thread, and having filled bottles of antiseptic Dettol and Savon liquid at hand. They attended to generations of women, sometimes even in the same family. One parturient woman reminded a 77-year-old masseuse of her long service: "*Mai* [mother], you know that you work for me, you work for my mother, and now you have to work for my children." The 77-year-old masseuse gave birth to most of her eleven children at her father-in-law's house without the assistance of a registered nurse or local village midwife. It was only after "the baby come out" that she sent her husband to seek help.

Masseuses today continue to attend to home births only when there is an unexpected, sudden emergency. One masseuse last attended to an emergency home delivery in 1994. The expectant un-married mother had not made any effort to go to the hospital because "she didn't have soap, towel, nothing, to take to the hospital." She soiled the bedsheets because there was no enema available. The masseuse used a sewing thread to tie the umbilical cord, and a razor blade to cut it. The afterbirth was not expelled automatically and the masseuse made her blow into a soft-drink bottle "to add pressure" to her womb. Another masseuse attended to a parturient woman in 1995 who had been sent back to her home after the nurses at the hospital informed her that she was not ready to deliver. She had the baby at home prematurely, after which the masseuse was called to attend. One of the masseuses' daughters has eight children, seven of which were born at home with her assistance. They massaged the back and pelvic area of the parturient woman during labor and delivery (see also Kay 1982). Unlike women in Uttar Pradesh, India, in the 1950s (Luschinsky 1962), Trinidadian Indian women

did not squat on a low wooden stool or on the floor for delivery.[8] The majority (85%) of masseuses interviewed (n=34) said they feel confident that they can assist in a delivery at home or the hospital (Figure 5-2)

Sixty-two percent of the traditional masseuses interviewed attempt to re position the breech or transverse fetus of an expectant primigravida mother after eight month of pregnancy Others (38%) refer their patients to an obstetrician who is likely to resort to a cesarean-section surgery as a last alternative. Less than ten percent of women with breech pregnancies seek the aid of a masseuse as a first choice in having her relocate the fetus to a cephalic position (Table 4-1) These were mainly Indian women, whose feelings about their abnormal fetal position were confirmed by their physicians Women in this condition, in Trinidad, visit a masseuse as a prevention against having to risk fetal death during a breech delivery, and the pain of a prolonged labor Masseuses know from experience that when a baby is born with its feet first the mother "bear[s] too much pain." Obstetricians say that fetal death can occur from asphyxia or intracranial hemorrhage from a tentorial tear produced by sudden changes in intracranial pressure (see Pinker and Roberts 1967:153) A visit to the masseuse could also mean saving about US $2,500 which is the expense of a C-section delivery in a private hospital. Masseuse believe that when the fetus remains in breech ("bridge) presentation at the onset of labor, obstetricians 'are quick to put knife on ladies."

Masseuses believe that one symptom of a breech pregnancy is the feeling of pain by the expectant mother on one side of her abdomen and a feeling of "emptiness" on the other The problem may be so acute during the ninth month that the patient is unable to walk, and masseuses are asked to do a home visit. ("When the baby resting on one side, the leg does kinda drag with the weight") Masseuses diagnose whether the fetus is in a breech or



Calculations exclude basic maternal and infant massage, the application of abdominal bands, the treatment of the evil-eye, and *hassuh*. These are conditions which all of them can treat.

Figure 5-2 Frequency of conditions which masseuses claim they can handle

transverse position by gently probing the sides of the abdomen with both hands in an attempt to locate its head. If the underneath of the abdomen feels hollow, it is likely that the fetus is not properly placed. They may also place a drop of oil on the top of the abdomen. If the drop runs sideways rather than straight down, a breech pregnancy is diagnosed. Some masseuses verify their decision by examining the shape of the abdomen and listening to the beat of the fetus's heart. Masseuses believe that breech and transverse pregnancies are caused when the expectant mother is "sitting down most of the time," "sitting too much in a hammock," sleeping habitually on one side of her body and not being habitually active. This behavior causes the baby to move to one side and settle there.'

If the fetus is found to be "cross" or "sideways," and is more than eight months old, they would attempt to rotate ("fix and straighten") it by external inversion in utero. Inversion is done by massaging and shaking the woman's abdomen, lightly at first, and then vigorously "to ease up the baby from where it stick up or sink down." The masseuses' palms, lubricated with coconut oil, are always placed on the opposite sides of the abdomen. The procedure is often painful, but since the perceived alternative is a C-section, women prefer to bear a few minutes of agony (see also Jorden 1978). Masseuses would like to apply this procedure during labor but are debarred from participating in institutionalized deliveries. Obstetricians in Trinidad believe that it is possible to safely turn a fetus by external version but they choose to deliver babies by cesarean sections, particularly if they are either large or small for dates (see also Adamson 1983). Masseuses recognize that trying to turn a fetus to a cephalic position is a delicate, complicated and dangerous procedure: "You have to know how you turning that baby, otherwise that baby could pass away in the mother belly."

Treating Backaches

Masseuses in Trinidad also treat backache by using a variety of traditional cupping methods. One technique is to place a teaspoon of pot salt or rice grains on a piece of cloth the size of a handkerchief. The salt is bunched and the ends of the cloth are tied together with a thread. The masseuses set the flayed ends alight by torching them with a lighted *deeya* [earthen lamp]. The lighted ball-shaped lamp is placed on the affected body part. A *lota* [brass jug] is used to cover the lighted cloth which "pull[s], 'hold[s] and "draw[s]" the pain. This procedure is done twice daily on the back and under the navel if the problem is diagnosed to be an abdominal disorder.

The other modified traditional variation, used by Hindu masseuses in a hurry, and by non-Hindu homecare providers, is 'glassing' (see also Behar 1993:108). A one-inch long stick of candle is mounted on a coin sat on the affected area, and a glass is turned up-side down over the lighted wick. Another method is to pour a few drops of puncheon rum on a cloth which is used to wipe the inside of a thick drinking glass. A match is struck, and flames quickly engulf the inside of the glass. The lighted glass is quickly placed on the affected area, and the flesh puffs up inside the rim. The flames consume the oxygen inside the glass after a few minutes until they are extinguished. The glass or *lota* then tilts sideways and falls after the complaint is believed to be cured. Prayers are not recited during this procedure.

Treating *Nara*, *Boochet* and *Khana*

Trinidad masseuses also treat Indian-specific physiological complaints like *nara* and *boochet*. The latter is described as "something like a ball" or a "lump" located under the breastbone. The organ drops or shifts when a person lifts or pushes a heavy object, or trips and falls suddenly. It is believed that weakness of the body can also precipitate the disorder. The main symptoms are vomiting when anything is ingested and the feeling of chest-pain ("You can't even drink water, it coming back up"). The problem is treated by massaging with both hands simultaneously, moving them from the sides of the body to the center, and then re-locating the *boochet* with the index finger. It is also treated by "glassing" which "sets" the organ back into place.

Nara is a condition of a dislocated vein characterized by abdominal pain, nausea ("bad feeling") and vomiting ("belly going off") with or without diarrhea, lethargy, poor appetite and general malaise. Physicians I interviewed approximate this condition with "torsion of the omentum," which is an abnormality caused when the omentum twists on itself, cuts off the blood supply, and sometimes causes abdominal pain. The omentum is described as "an apron of fat that hangs from the stomach and covers the intestine." Masseuses diagnose *nara* by placing their thumb firmly on the abdomen just above the navel where they feel a rhythmic "beat," "grumble" or "bubble." Medical practitioners argue that this sensation is really the pulsation of an aortic aneurysm which is a balloon-like swelling of an artery due to a weakness in the vessel wall. Folk medical practitioners claim that while appendicitis feels soft, *nara* is hard like a lump, so that there is no danger of rupturing an inflamed appendix while massaging as doctors fear.

Like *boochet*, both men and women suffer from *nara* and it is possible for a person to suffer from both complaints concurrently. But while *nara* in men is usually treated by "cracking" by male bone-setters, in women it is treated by "rubbing" by masseuses.[10] Treating this condition is done by a series of firm strokes directed towards the navel. Physicians maintain that vigorous massaging can be 'dangerous" because it can cause a blood vessel (anorthic aneurysm) to rupture and can lead to "instant death." Based on my knowledge as a person who has spent almost all his life in Trinidad, and that of my folk medical and postnatal informants, there is not a single known case of a person who has died "instantly" under the hands of a masseuse. Trinidad physicians admit, however, that these manipulations can "somehow help to untwist the omentum in the abdomen when the folk practitioner puts her hand on the patient's belly."

In treating *nara*, the bone-setter ("massage-man") usually instructs his patient to lie flat on his belly on the floor and relax ("to get the bones loose"). He "crack[s]" him by asking him to turn on his side while he sets his foot on the patient's waist and jerks one arm. The procedure is repeated on the other side. The patient is then asked to stand and lace the fingers of both of his hands behind his neck with elbows pointing toward his toes. The bone-setter stands behind him, wraps his hands around his arms, lifts him off the ground, and jerks him until he hears a "cricking" sound emanating along the spinal column. The patient would also be asked to lie on his back on the floor and flex his knees. The bone-setter would place his hands on each knee, and push the knees suddenly towards the abdomen. Again, a "cricking' sound is expected to emit from the hips and lower spine. It is believed by folk healers that, if left untreated, *nara* can form a hard lump ("knot") around the navel which would have to be dealt with by a specialist physician.

Treating Sprains

While Trinidad bone-setters ('massage-man') treat sprains by manual traction ("cracking"), masseuses treat the same problem, mainly among women, by "rubbing," and the application of herbal poultices. The latter method, however, has become almost obsolete with the promotion and availability of pharmaceutical products like soft candle. Only 12 percent of the masseuses in my sample (n=34) said that they still use brown paper soaked in vinegar as a compress. About the same proportion of them treated sprains by cutting an egg plant ("baigan") in half, pasting salted butter on the insides, and tying them on the affected body part.

They recalled that the generation of masseuses before them, treated sprains by applying wild saffron, harjor, wild onion, white lime, talla grease and rope imported from Germany. Some of the ingredients would be chopped and then placed in a mortar where they would be pounded. Then, they would be heated in a pot, and the moist mass would be spread in a castor oil leaf which would be placed on a head veil (*orhini*). The poultice would be wrapped around the inflamed part of the limb and remain intact for about four days. It was applied as "hot as the person could bear." When the cataplasm was removed, the masseuse would rub the affected area and apply a new one. She would "massage the nerves, the veins [illegible] and shake the foot and the bone would go, 'Crick!' And it set." Masseuses nowadays believe that commercial adhesive plasters are not satisfactory. "It falling off in two-three days. Until the 1940s, they used the sap of the trunk of a chataigne, matapal or breadfruit tree as an adhesive. The "wax," used by cobblers, was also a good substitute for treating any dislocated ("unranged") musculoskeletal problem.

Treating *Palai*

Palai or "pressing," recognized by physicians as asthma or bronchitis, was last treated by masseuses in Trinidad in the 1950s. Masseuses diagnosed this respiratory problem by observing that the area around the umbilicus of a child or adult was "jumping," and the chest "beating hard hard." They *jharayed* [treated] the complaint by joining their [masseuses'] thumb and smallest finger of one hand together, and making a circular motion. The motion was performed five or seven times around the affected the navel while a *mantra* was recited. Instead of the fingers, a knife was also used.

Performing Abortions

Abortions are illegal in Trinidad except for the highly restricted "therapeutic abortions" which must be carried out within the first trimester of pregnancy by licensed medical practitioners. However, some family doctors routinely perform abortions in their private clinics to any woman who has the money to pay. The cost of the abortion depends on the stage of advancement of the pregnancy which is currently US $170 per month.[11] Other doctors are unknowingly seduced by their clients who tell them that they need medication to resume menstruation.

Backyard abortionists, who are usually females, are really the locally known specialist in this area of secretive operation. Because of how they think human/women's bodies work, they seldom make use of sharp instruments, like wire hangers or poisonous cassava sticks, to puncture the fetal bag of water. As Sobo found in Jamaica, purgatives are more often used because it does not make any sense to "pull out" what can be "washed out." This procedure also minimizes the risk of permanent disability or death from

sepsis hemorrhaging, uterine perforation, lower genital tract injury, renal failure and embolism (see UN 1995:79). In any case women who visit backyard abortionists sometimes end up in public hospitals seeking post-abortion treatment (Chouthi 1988) when pain and bleeding increase, and/or when the fetus and its sac are not expelled (Marshall *et al* 1983). The post-abortion ward at Port-of-Spain General Hospital is popularly referred to as "the slip and slide ward" because of the high rate (50 patients weekly) of women who are admitted for botched or incomplete induced abortion (Rampersad 1996:11). When questioned by the hospital staff about their condition, most women claim that they miscarried because they had accidentally slipped and fell.

Most women adopt self-inducing methods at home before visiting a doctor, backyard abortionist or masseuse. The use of home remedies varies with the availability of the ingredients and the stage of the pregnancy (see Simpson 1962). Home remedies often include the ingestion of substances considered to have "strong," "bitter" or purgative qualities (Appendix C). Parturient women stress their bodies with hard manual work, or jump, to "bring down" the fetus. Another home remedy to induce abortion in Trinidad is the increasing use of an over-the-counter drugs like Cytotec, Misoprostol or Searle which is sold without a prescription (Rampersad 1996).

It is not unexpected that masseuses, who are the recognized folk gynecologist and obstetrician in the community, sometimes provide this kind of lucrative service. However, only six percent of the masseuses I interviewed (n=34) confessed that they performed clandestine abortions. Yet they did not want to be publicly identified for fear of the law and social condemnation. Those who did not perform the practice do so for religious and moral reasons.

"You can't save life and then you want to destroy it." One elderly masseuse whispered in mischievous tones to me about another village colleague

> It had a time when she used to dig out child and throw away. But now she go down deep in [religious] devotion and she stop now

The procedures they prescribe are often the same as those used by pregnant women themselves at home. Traditional masseuses' methods of abortion may also include the use of horse's oats boiled in stout and laced with a few drops of puncheon rum. The potion, taken by mouth, is expected to "make two-month and three-month baby fall." Another potpourri is made by boiling young guava, black stage, caraille and cashew leaves of which a cup is drunk for three mornings consecutively

The roots of a wild coffee plant are boiled and also drunk to "pass out" the fetus. Other abortive brews include green pineapple soaked in white rum, boiled mauby bark, the boiled roots of the tea marie plant, the boiled leaves of the zeb-a-pique tree, aloes, stout, and epsom salt. Figure 5-3 illustrates the frequency of items mentioned by the 34 masseuses I interviewed. As in Asia (Sambhi 1977), a follow-up procedure is the use of the hands of the masseuse to press deeply on the lower abdomen of the pregnant woman in an effort to "squeeze" the fetus out. Masseuses admit, however, that sometimes "you could drink all kind of bush, and it still wouldn't go." This belief is consistent with doctors' view that a healthy fetus is almost impossible to dislodge.

Like their knowledge and skill in making the fertility "plug[s]," the specialty of performing abortions attracts non-Indian clients to these mainly Indian/Hindu masseuses. An examination of 210 randomly selected medical records of postnatal women at Mt. Hope Women's Hospital reveals that more non-Indian (56%) than Indian (44%) women had either a spontaneous or induced abortion.

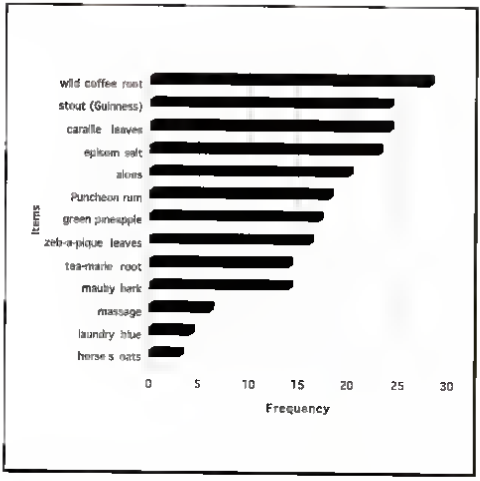


Figure 5-3 Frequency of abortion items used by masseuses (n=34)

This finding is consistent with that of Harewood and Abdullah (1972, 32) which reveals that the proportion of women who had an induced abortion was higher for women of African descent than for those of other racial groups

Summary

Since masseuses in Trinidad are the key custodians and practitioners of traditional medicine who specialize in the treatment of mainly low-income women, they represent a symbol of resistance to the dominance of capitalistic male medicine (see Singer 1990a) The socio-economic divergence between healer and patient is small compared to that of the physician and his client. Being skilled as a folk medical practitioner does not automatically place the masseuse in a separate privileged class, or set her apart from the exigencies of life in the low-income community in which she lives and serves (see also Kerewsky-Halpern 1985) The low-income patient is not constrained by expressing her most private problems to the masseuse in the Trinidad English dialect that both of them speak spontaneously In Trinidad society, where the activities of the majority of women were confined to the domestic sphere up the 1960s massaging provided the only avenue for low-income women to participate in community service in the public domain (see also Sargeant 1982) Massaging, therefore, can be seen as a thinly disguised protest movement directed towards wage-earning male physicians (see Lewis 1971)

Notes

[1] I define a traditional masseuse as one who has had no formal training in massage therapy, and is recognized by the community as having specialized knowledge and skill in treating patients (see also Sargent 1982:63)

[2] I have discussed the 'Creolization' vs 'Indianization" cultural dialectic in Trinidad elsewhere (Mahabir 1986, 1996)

[3] Daughters in such inter-generational family networks have been called the "sandwich generation" or 'the woman in the middle." They face multiple responsibilities of providing support for their parents or parents-in-law as well as their own children in addition to coping with their husbands' expectations.

[4] One 75-year-old widow confessed that it was only when her husband left her in the 1950s (because she was believed to be infertile), and she became a single woman, that she became happy. She was then free to cook what she liked, dress in new clothes, and travel wherever she wanted without having to ask permission.

[5] This figure can be compared to the 1,051 physicians, 2,266 nurses and midwives, 1,259 nursing assistants, and 166 nursing aides in 1993 in Trinidad (CSO 1993:2)

[6] Unlike the *dai* [midwife] in India in the 1920s (Mayo 1927), and the *sobadora* [midwife] in Guatemala in the 1980s (Rocha 1991) payment to a Trinidadian masseuse does not vary with the sex of the child.

[7] There is no anatomical term in Western medical science synonymous with "mattress." Masseuses point out that it supports the womb/uterus and grows big as a marble during pregnancy.

[8] There is still the vestigial belief in *rakshas* --deformed fetuses with grown hair, two long teeth overlapping the lower lip and a rat-looking face. Their ears were described as 'flatty, flatty' and their eyes were 'bulgy.' They squatted on all four limbs which were thin, crooked and long 'like a crapaud [frog].' They were almost always still-born. If they were born alive, however, it is believed that they had the capacity to jump and crouch on the mother's chest, or fly through the window to the top of the roof to await a convenient time to pounce and kill both parents. This fear led midwives to suffocate them instantly upon delivery. *Chuggalias* or *bhillinays* [village news-carriers,] of course, exaggerated about the physical features and capacities of these fetuses. Only two of the 34 masseuses I interviewed claimed that they actually got a glimpse of a *raksha*, but which were without wing-like limbs.

The descriptions of the others were based on second hand sources My belief is that these *rakshas* were the result of a mal-nourished mother and/or an incomplete abortion. Masseuses think that these are the living results of the parents' or grandparents *karma* [retribution] 'You can't plant mango and expect to reap tamarind. My old parents say, 'Your deeds have to run for seven generations."

[9] Feminists childbirth educators (e.g Miriam 1984) argue that when a birthing woman is squatting, and supported by others, her pelvis will be completely open, and she will be able to take full advantage of gravity

[10] Another method of *jharaying* [treating] *nara*, practiced up to the 1950s in Trinidad, was with the use of bamboo strips and prayers. The healer stood in front of the patient holding two strips of bamboo, about one foot long, outstretched in his hands. While the healer was reciting *mantras* [sacred formulae], the two strips would draw towards each other as an indication that the complaint was being cured

[11] In 1995 the death of a woman from attempted abortion, performed by a medical doctor was reported in the local newspaper (Alonzo 1995.1) The woman was about four months pregnant and was injected with a controlled poisonous drug to induce an abortion

CHAPTER 6
CARE OF THE NEW MOTHER

In all societies (see Baumslag 1987, Levitt 1988, Pillsbury 1978, Snow 1993), there are similar concerns and practices concerning the postpartum period. The following list provides a framework for understanding the postpartum period in any society:

(1) A set number of days when the woman is secluded and/or rests.
(2) Foods and activities which are restricted.
(3) Special foods and activities which are considered beneficial.
(4) Methods to increase milk flow.
(5) Methods to heal the birth canal.
(6) A ritual which formally ends the seclusion period.
(7) Methods to heal the uterus.
(8) Restrictions on sexual relations.
(9) Methods to help the woman regain strength.
(10) Methods to make the baby strong and prevent illness.

Traditional postnatal practices in Trinidad are integrated into a holistic set of customs embedded in a largely unquestioned cultural tradition (see also Laguerre 1987). During the lying-in period, home and community health-care providers try to restore the thermal balance and physiological functioning of the body which were disturbed during pregnancy and childbirth. They also try to prevent future illness and misfortune by a variety of regimens which range from prayers to pills. Restrictions are imposed for the new mother against

reading sewing and watching television for fear that their "weak" eyes would be damaged ("That is a true true thing you know") The fact that postpartum blood--like menstrual blood--is seen as polluting is one reason why it must be flushed from the body, and the woman is prohibited from participating in certain clean activities (see also Snow 1993.225, Williams 1979 47) Before the 1960s in Trinidad, Hindu women returned to their natal homes to be attended by a low-caste midwife/masseuse because their in laws wanted to prevent their own homes from becoming *chutti'yar* [sixth-day pollution] Purification is still observed today through a birth ceremony marking the changed status of the new mother in her *rite de passage* After the ritualistic use of smoke fire, and water on that propitious day, the woman becomes touchable again.

Seclusion and Pollution

Strict postpartum taboos are observed by women of all racial and ethnic groups in Trinidad for fear that harm, or even death, may befall them and/or their newborn child One such taboo is the prohibition of the lactating mother from visiting a house of mourning ('dead house'), cremation ground, or cemetery If someone in the family dies, all young children are crossed over the coffin as a precautionary measure against the spirit of the dead "troubling" them after the body has been buried or cremated There is the lucidly articulated feeling that a woman in a polluted state is more vulnerable to attack by evil spirits, hence the safeguard of having amulets and a light burning by the bedside during the puerperium (see Chapter 7) Parturient Indian women believe that a *churiel* [ghost of a woman who has died during childbirth] is the most malignant spirit to roam the land (see also

Kakar 1982) Before the 1960s the midwife/masseuse disposed of the chamber pot ("posy") because the new mother was not allowed to visit the outhouse And newly-delivered mothers were confined to the house and to a particular room for others reasons as well

The phenomenon of birth, like menstruation, carries with it the idea of the ceremonial untouchability, hence the numerous precautions and taboos observed until the new mother is "clean" again. Hindu postnatal women are prohibited from participating in ritual or religious activities like *pujas* [ceremonial worship], temple activities, weddings, etc Precaution is exercised in coming into physical contact with *pandits* [Hindu priests] who are exclusively males of the higher caste Care is also taken against touching amulets less they immediately loose their potency (see Wilhams 1979) Even when supplication is being made to the deities during the morning of the *chauti* [sixth-day ceremony], the new mother is not allowed to stand near the *jhandi* [flags on the family's shrine] in the yard. Indeed, no kind of Hindu ceremony is held in a house in which a new mother is present because the place is considered *chuttiyar* [sixth day pollution] (see also Burghart and Reissland 1989) Like their Rajputs counterparts in Khalapur, India, in the 1950s (Minturn 1963), "unclean" Trinidadian women were, around the same time, not allowed to sweep, enter the kitchen, cook, serve food, or eat in regular utensils

All the biomedical practitioners I interviewed (n=30) agree that the newly-delivered mother should not perform any household or other physically-demanding tasks During the postpartum period, her role as a household worker is put in abeyance and is temporarily replaced by another female member of the family, or the masseuse Like her counterpart in her natal village in rural North India in the 1980s (Jeffery and Jeffery 1993), the

Trinidadian woman is perceived to be in a condition of weakness and vulnerability. She is expected to refrain from sexual intercourse, because her body is believed to be still polluted with "bad" blood, and the joints are considered to be still "open." While it is difficult to enforce sexual abstinence during the puerperium nowadays, a child born within one year of the last sibling is still looked upon unkindly as a *lamáyra*.[1] In the old days, the midwife/masseuse would perform the role as the chaperon who would sleep in the same room with the new mother. A *lamáyra* child is considered to be born out of an unclean" womb, and is vulnerable to fatal attacks by lightening (*lajàli*). As among Haitian villagers (Alvarez and Murray 1981), it is expected that such a child would grow up being underweight, emaciated, and sickly. Spiritual and physical normalcy is understood to begin to resume when postpartum bleeding has stopped completely.

Trinidadian women believe that their pores, joints and womb become "open[ed]" during pregnancy and do not "close" until a few weeks postpartum (see also Alvarez and Murray 1981:26). This condition makes them vulnerable to the ill-influences of "cold" and "wind" which may enter through open doors and windows to penetrate uncovered bodies and spread legs. A woman may also "catch lining-cold" by coming in contact with cold water through bathing, doing laundry or washing dishes. Cold is believed to enter the anatomical system through the pores, head, soles, and the nine orifices of the body (see also Pillabury 1978). During the night when dangerous elements are felt to be more virulent (see Chapter 7), the doors and windows of the confinement room are not only shuttered, but also protected with amulets against wind-borne evil forces that can cause harm to mother and child.

Like the hot-cold concept (Foster 1953, Gonzalez-Stafford and Gutierrez 1983),[2] the prevailing traditional belief posits that the body is "open" and "cold" during postpartum, and must be "warmed" and "closed" back to its pre-pregnancy stage with the help of confinement, massage, abdominal bands, postpartum exercises, warm foods, steam baths, hot teas and "heated" herbs (see also Cooper 1993, Laguerre 1987, Mata 1978). Most of these therapeutic interventions are made to restore the temperature balance in the body which was upset by the birth process. As during menstruation, the body is believed to be in an "open" and "cold" state due to the out flow of "hot" blood from the anatomical system. If the equilibrium of "hot and cold" is not maintained by a certain time, severe illnesses are expected to ensue. Internal and external interventions are, therefore, classified as "hot/warm or cold." With respect to Indians in Guatemala, Cosminsky (1982:226) explains that

> the importance of heat ... seems to be not only related to the hot-cold balance but also to the concept of cleansing of pollution. Heat has semantic associations with blood and fertility, both symbolic of women. Blood is usually considered "hot," although there are varying degrees of hotness. A pregnant woman is considered as being in an unusually hot condition, whereas after delivery, the woman is in a cold state, both from the loss of blood and the expulsion of the baby.

In the Trinidad folk medical context, heat (in whatever form) is also considered nourishing for both mother and child, as well as cleansing and purifying, both physically and spiritually. The use of smoke and fire in the Hindu postpartum ritual is illustrative of this concept. The proscription against consuming "cold" foods and liquids is efficacious in that it demands everything be cooked or boiled, thereby destroying pathogenic micro-organisms that might otherwise be ingested.

Special Foods

Trinidadian postnatal women of all racial and ethnic groups believe that they cannot recuperate properly without the consumption of certain beneficial foods (see Springer 1979). Generally, they consume more fluids than at any other time in their life because of the loss of liquids in the form of blood and breastmilk (see Chapter 7). African masseuses prescribe that Sheen of Hemoglobin--which can be bought from the pharmacy by wealthier women--is the best tonic "to put back lost blood." Natural drinks like coconut water, and "nourishing" canned food-drinks like Lasco, are also recommended. African women consume more cereals than their Indian counterparts in the form of porridge made from pulses and beans. Unlike the consumption of pasteurized cow's milk which is 'light and tends to make you feel hungry every minute,' cornmeal porridge is considered to be both satisfying and sustaining. The most frequently consumed dish of all postnatal women, however, consists of a hot broth made from ground provisions, vegetables and meat (usually chicken) which is felt to be "strengthening."

"Setting" the Womb Back in Place

Unless the postnatal Indian mother in Trinidad has undergone a cesarean-section, she is massaged with coconut oil twice daily from the day of hospital discharge until the twelfth day. Gentle massaging is done to help relieve the aches ("pain in the bone") and exhaustion ("tiredness") of childbirth. Deep postpartum abdominal massage is done to the bare skin to squeeze the "bad blood" out and to "set" mother's womb back in place and shape. It is also done to prevent long- and short-term illnesses resulting from

displaced and enlarged organs altered during pregnancy, labor and childbirth (see also Cosminsky 1982, Fuller and Jordan 1981). Fibroid ("fry ball"), for instance, is believed to be the result of "bad blood" left in the womb.

Masseuses and elderly grandmothers maintain that the failure to observe traditional postnatal practices is sure to lead to illness or complications. "They wouldn't feel good" and "They will be sick sick." It is believed that continuous rubbing of the abdomen during the puerperium would help it regain its "flat" shape which had been stretched to its limit during the nine months of pregnancy. Massaging the abdomen also enables the "nastiness to come out;" the complete emission of which is believed to be achieved when the abdomen is not only massaged but also shaken with the masseuse's hands and wrapped with an abdominal band. Thus "nastiness" is what biomedical practitioners describe as lochia--the vaginal discharge which is emitted during the first week or two after childbirth and gradually turns from reddish-brown to yellowish-white (see Cronk and Flint 1989, Katchadourian 1987).

Some masseuses believe that foot massage of the new mother is the more effective means of completely expelling the "nastiness" from the uterus. This method was popular before the 1960s in Trinidad among "long-time maidy [midwives]" and is not known to be practiced frequently anywhere else in the world. It is performed when the masseuse sits on a bench, or on the edge of a bed, while the mother lies on the floor. The masseuse is able to exert greater force with the sole of her foot than with the heel of her hand, especially if she is weak from age or illness. She uses her foot to 'squeeze' the woman's back, waist, hips and legs rhythmically. One masseuse, who still uses this technique, explains:

> I know what I doing I know how much weight is in my foot, I know how much pressure the patient could bear

The practice of pressing the oiled head of the midwife/masseuse against the abdomen of the standing mother seems to have disappeared by the 1950s in Trinidad. This method of pushing the 'bad blood' down and out of the new mother's body was observed in Uttar Pradesh, India, in the late 1950s (Luschinsky 1962). The vaginal discharge is described as "pitching out like clad blood . . . sometimes it does look like a little baby head." Obstetricians maintain that clots may be evident, or an even heavier flow may occur, in some women which are due to bleeding and slouching at the placental site (see also Coustan and Angelini 1995). The final phase of the discharge contains leukocytes, microorganisms, mucus, and debris from the uterine lining, or cast-off decidua (Coustan and Angelini 1995:344, Hull 1986:285).

One of the most widespread traditional postnatal practices in the world is the binding of the mother's abdomen (see Cosminsky 1976, Jordan 1978, Solomon 1990, Staker 1992). The band is worn by all racial and ethnic groups of postnatal women in Trinidad except when an episiotomy or cesarean-section is performed. It is applied primarily to "squeeze out all the bad blood," and to ease postpartum after-pains for which a physician would administer an analgesic. The band is also used to hold ("set") the womb in its pre-pregnancy location and to prevent it from "slipping down." The "mattress" is also "pulled" to its normal location, thus is a special reproductive organ located near the embryonic sac and the placenta for which there appears to be no counterpart in modern anatomical science (cf. Alvarez and Murray 1981:29). A rare symptom of a woman's womb being displaced is her inability to walk upright comfortably without support. A parturient's

woman whose womb is "out of place" would be unable to carry a full-term child successfully. Failure to massage the abdomen and apply an abdominal band after delivery would also result in a mother's belly remaining swollen ("raise up high" or "showing").

It is believed that the "cold air" from the delivery room air-conditioner blows into the "open" vagina and results in a bulged postpartum abdomen. Like their postnatal counterparts in Jamaica (Sobo 1993:68), Trinidad women use maternity pads to prevent "air" from entering the womb through the vaginal opening. The masseuses manipulation and band also prevent the abdomen from remaining "flabby and big," from "lapping," and from becoming "fat." Physicians acknowledge that in the immediate postpartum, the abdominal muscles are "flabby," "lax" and "soft" due to due to stretching of the overlying muscles from the enlarged uterus. If muscles remain lax, a diastasis recti, or marked separation of the rectus muscles, may be detected on abdominal palpation. If this diastasis persists, the muscle area fills in with peritoneum, fascia, and subcutaneous fat (see also Coustan and Angelini 1995:345; Youngkin and Szmania 1994:520).

Up to the 1960s in Trinidad, Indian masseuses made postnatal abdominal bands ("belly band[s]") by cutting six-inch-wide strips from a worn cotton *dhati* [loin] cloth. Other masseuses cut strips from from the "soft" empty flour bag, bought in the open week-end market, to prevent the cutting of the skin. Nowadays, masseuse use strips cut from an old bedspread. The cloth is folded into a broad belt, and the ends are knotted or pinned and tucked inside, while the woman is lying on the bed or floor. New mothers who do not have the assistance of a masseuse or elderly caregiver wrap the bands themselves with the aid of any close person at hand. The band is usually worn for nine days after delivery, but is best recommended for as long

as a month. A soiled one is discarded every week and a new band is replaced. It is temporarily removed about half an hour before a bath to allow the skin to "get cool." Masseuses and elderly grandmothers lament the fact that not all new mothers nowadays are observing traditional postnatal practices and they, therefore, are failing to reverse a number of potentially harmful processes. "Plenty people believe that it is long time thing, but that is why long time people was healthy and strong."

To set the womb back in place, the standing mother is asked to bend forward over a bed with her hands placed on the edge of a bed. The masseuse stands behind, and places the sole of her foot on the woman's clothed buttocks. The masseuse pushes her foot in short rhythmic thrusts. The new mother then turns and bends backwards in an arch while the masseuse places her sole on her vulva and performs the same motions. A similar postpartum exercise is performed with the masseuse's sole being pressed against the woman's vulva. In this posture, the woman is required to sit on the floor with her legs outstretched and with both hands holding the arms of the standing-bending masseuse. The masseuse helps the mother to rise by pulling both hands (Figures 6-1 & 6-2). The patient, who sits on the floor, holds the nape of the masseuse's neck and pulls herself up. The masseuse simultaneously squeezes the abdomen with both of her hands which helps to "send the womb back in place."

While biomedical practitioners argue that the womb/uterus will return to its natural non-pregnant size without any outside help, they maintain the same cannot be said of the muscles of the abdomen and pelvic floor which have been stretched by the pregnancy. These muscles have to be "tightened" by means of postpartum exercises under the direction of a hospital physiotherapist. Postpartum exercises help to firm the abdomen,

Figure 6-1 Postnatal exercise. The masseuse (right) places her foot on the vulva while the new mother stretches to grip her arms

Figure 6-2 The new mother exerts pressure on her abdomen by trying to stand up The masseuse offers her arms and instep for support

tighten the pelvic floor muscles, stimulate blood circulation, and aid in the healing of sutured episiotomies (see also Adamson 1983 Cronk and Flint 1989, Stoppard 1994)

The masseuses' notion that the womb of a parturient woman is not in its normal size and location, and has to be 'set' back during the puerperium, is not inconsistent with the biomedical understanding of the female reproductive organs ("Remember when the woman making the child, she pushing everything out") Physicians I interviewed (n=30) said that after delivery, the uterus contracts markedly (involution) and gradually regains its pre-pregnancy size and shape For about six weeks during postpartum it continues to contract, sometimes causing slight cramps (afterpains) which are most noticeable if the lactating mother is breastfeeding or is multigravida (see also Adamson 1983 108, Hull 1986 285, Katchadourian 1987 120)) Within two weeks postpartum, the uterus decreases further in size, descending into the pelvic cavity and eventually below the pubic symphysis. "Contraction and retraction of muscles compress the uterus, reduce uterine blood supply, and diminish the overall uterine size and shape" (Coustan and Angelini 1995 342)

Herbal Baths

Postnatal Indian women in Trinidad (whether Hindu, Muslim or Christian) usually take their first full bath on the sixth day after delivery Non-Indian women frequently bathe on the ninth day (see Springer 1979) Hindu women often consult a *pandit* [priest] on what day the bath should be taken, and also on what cardinal point they should face when taking the bath. If the temperature on the stipulated day is felt to be "rainy," 'chilly' or "cold' because the sun is not shining, the bath is postponed for the next day

for women of all racial and ethnic groups On the specified day of the bath the head-hair of all women is washed and shampooed for the first time since delivery For both Hindu and Muslim women, the first postnatal bath is physically and ritually significant because water, like fire is a purifier that could wash away all forms of uncleanness and pollution (see also Cosminsky 1982, McGilvray 1982, Williams 1979) The twelfth day, on which the second bath is taken, marks the end of the customary transition from the most polluting and dangerous postnatal phase. This day also marks the end of the masseuse's duties and the new mother's seclusion

During parturition, the body is believed to be "open" and therefore, internally and externally vulnerable to the harmful effects of "cold" elements like unheated water and wind/air Accordingly, all women take precautions from catching the potentially infertile and fatal lying-in ("lining") cold by abstaining from a bath until the sixth or ninth day postpartum.[3] Even on the specified day, the water is brought to a full boil and cooled to just a tolerable degree or, better yet, poured into a container which is placed in the sun This established tradition runs counter to the instructions of the hospital nurses who require new mothers to stand barefooted on the 'cold' bathroom floor and bathe in cold water on the morning after delivery

Some of the culturally-sensitive nurses modify their instructions by advising mothers to bathe but to avoid wetting the hair of their heads New mothers at Mt. Hope Women's Hospital told me that they use a delusive strategy to satisfy both the hospital staff and their own cultural beliefs. They enter the bathroom, turn on the water, but do not get themselves wet The soles of their feet, which are considered to be vulnerable points of entry for "cold," however, still come into contact with the bathroom tile. Although Trinidadian physicians do not believe that "cold" can enter the "joints"

through the soles and pores, they concur that the boiling of water by masseuses and grandmothers indicate an awareness of illness precautions. Doctors argue that when water is boiled, pathogens are destroyed, and this is particularly important when water is being used on the genital area in which the lacerations may not have yet healed.

The purpose of a postnatal herbal bath in Trinidad, like the "leaf baths" in Haiti (Alvarez and Murray 1981:27), is to pull the woman's body together again, to close her pores, joints, womb, and genital and pelvic organs. At the same time, the bath is meant to restore warmth in the "open" cold anatomical system.[4] The plants are considered "hot" because of the presumed heating effect they have on the body (see also Cosminsky 1982). A combination of the leaves of nine plants are crushed, boiled, poured into a tub/bucket/basin of bathwater and left to "rest" until it becomes luke warm.[5] The leaves are variable and comprise the plants of mango, fever-grass, orange, plum, hog plum, bamboo, guava, avocado, lime, caraille, calabash, lime, sweet broom, congolala, hogplum, malomae, St. John bush, ruction bush, zebapique, soursop, wild coffee, wild senna and black sage (Figures 6-3 & 6-4; see Appendix C for local family and botanical names).[6]

Of the 23 plants identified, hogplum, black sage, caraille and fever grass were the most frequently mentioned (23%, 22%, 17% and 13% respectively) by my female informants. Some of these plants are grown around the house while others are collected from unattended tracts of land. When the water is "fixed" for her, the new mother is ready for her first "bush bath" after childbirth. Springer (1979:47) writes that

> [t]he woman is then bathed and she makes sure to hold some water in her mouth to prevent her from "taking cold." It is the first time her entire body is being exposed

since the baby's birth and so the bath is taken as quickly as possible

The masseuse or grandmother may sometimes assist the mother in bathing by grasping a handful of the boiled leaves and patting ('sapping') her on her body. The purpose of this motion is to help the warm herbs penetrate the pores of the skin so as to make the reproductive system warm, strong and whole again. For the very few women who do not use any kind of "bush" during the postpartum period, warm water is at least used to bathe.

Since the leaves are thought to have "bitter" therapeutic qualities, at least one mouthful of the strained warm brew, to which a "pinch of salt" is added, is drunk as a prophylactic against 'colds.'[7] Some masseuses drink some of the tea, together with their patients, to "clean" out themselves, to show empathy, and to establish a female bond. ("The bush does taste real bad you know.") As in Surinam (Staker 1992:88), certain leaves are believed to be effective against impurities, 'clad blood,' "cold" affecting the womb, and potential cervical and uterine cancer. "They will clean out the inside from any nastiness." It is on this day that mainly African women drink "a dose" of castor oil, olive oil or, seldom, "lamp oil" as a purge. For the very few women who do not take a herbal bath or decoction, castor oil is at least ingested. Women of all ethnic groups, like their counterparts in Jamaica (Brody 1985:169), sometimes drink aloes blended in a "hot" [unchilled or without ice] stout to prevent/treat afterpains and to "pass out the clad blood, and run out the nastiness." Until the 1960s, women drank a 'hot' stout blended with (condensed) milk and a hen's egg. Women who are taking doctor-prescribed drugs, however, do not drink any alcoholic beverage or "bush medicine" for fear of potential side-effects from the combined medication.

Figure 6-3 The leaves of the green sour plum plant are boiled and added to the bathwater

Figure 6-4 The leaves of the caraille/bitter gourd plant are also used

Before the full bath is taken on the ritually-specified sixth or ninth day, the mother and her newborn take a sponge bath with warm water on a daily basis. Since a postnatal woman's body is considered to be still "open" and, therefore, susceptible to catching "cold," it is ill-advised to use cold water to wash the vulva. If the new mother has sustained an episiotomy ("stitches"), she is instructed by the hospital nurses at Mt. Hope to sit over a bowl of hot warm water in which salt has been added. Vulval douching with the salted water is recommended both as prophylactic measure in reducing the risk of infection and as a relief for perineal discomfort. This is one of the oldest biomedical treatment still used in reducing maternal discomfort after delivery because of the possible antibacterial or antiseptic properties contained in salt (Sleep 1991).

Masseuses and elderly grandmothers add boiled hog-plum leaves to the salted sitz water and instruct women to sit over it "as long as they could bear the heat." African masseuses instruct women to soak their heads with a "cool" liniment, like Limacol, when they sit over the steam. If the head is not "cool[ed]," the rising vapor inside the body would "cause the blood to rush up to the head" and result in a stroke. Like their Jamaican counterparts (Sobo 1993), Trinidadian women believe that squatting over a pot of steaming hot water "melts" all recalcitrant pregnancy-related leftovers which are then passed out through the vagina ("They say you does actually feel the clad blood coming out"). Postnatal women drink the cold juice served to them by the hospital staff only because they feel dehydrated and thirsty. A hot cup of natural orange-peel tea is preferred but is not on the hospital menu. Cold drinks, and ice in particular, are believed to be clot the otherwise free-flowing "bad-blood" and cause fibroids in later years. The advice by one foreign medical authority (Griffin 1995:58) to use ice on incisions, in order to recover

quickly and reduce swelling, would be rejected outright by local women and their home-care providers.

The internal and external use of medicinal plants by the mother as well as for the newborn is condemned by biomedical personnel. They argue that though some of them may be effective, there may also be side-effects. Almost all of the plants used in the postpartum period have been botanically identified, but clinical trials are yet to be done to determine their physiological effects (see also Cosmunsky 1982). Some of them may contain active alkaloids which can check hemorrhaging and aid in the involution of the uterus which is one of the major physiological and biochemical changes characterizing the puerperium (Pillsbury 1978).

The *Chatti* Ceremony

Of all the childbirth ceremonies observed by various ethnic groups in Trinidad, Hindus perform the most complex one which is done at home rather than in a temple. The sixth-day postnatal Hindu *chatti* ceremony is both a celebratory social announcement of the safe return of the new mother and her newborn from the perils of childbirth and a rite of reincorporation into the family (see also Cosmunsky 1982, Dougherty 1978, Oakley 1980). The *chatti* also marks the end of the mother's postpartum confinement which was regarded as the most dangerous period for her and her newborn. The ceremony is also an affirmation of the culturally-expected role of a married woman as a successful social reproducer, especially if she has borne a son. This is one of the few Hindu religious events in which a female officiant (i.e. the masseuses) performs the role as a male *pandit* (priest). Since the rituals involved in this ceremony are considered "unclean," it is believed by local

panditi that these duties are more befitting of female officiants (see also McGilvray 1982). In other Hindu observances, like marriage ceremonies for example, female officiants (*nawa*) are relegated to the role of assistants to brahmin *panditi*. If the ceremony is held on the twelfth day (*barahi*) instead of the sixth,[8] the period marks the formal end of the masseuse's duties as a ritualist and as a caregiver. She is given gifts and money, but the compensation is comparably less than that which would have been paid to a *pandit* for similar services.

If there is one medicinal and edible plant which distinguishes Indian from non-Indian postnatal women, it is the use of the tumeric (*hardi*) by Indians in its manifold forms (Mahabir 1991). The plant is commonly cultivated by elderly Indian female home-care providers around the house. In this sense also, African masseuses have become "Indianized" through their adoption of it as part of their repertoire in treating Indian patients. From the day the new mother is discharged from the hospital to the sixth day, the rhizomes of the *hardi* and ginger plants are peeled, ground and boiled in milk. The mixture is strained in a cup to which (condensed or pasteurized) cow's milk and sugar are added.[9] The new mother is advised to drink the brew on mornings and evenings "as hot as she could bear in order to help the clod blood melt and run out." ("That better than anything you could drink") Just as among Mathil women in Nepal (Reissland and Burghart 1989) and Indian women in Uttar Pradesh, India, (Luschinsky 1962), the brew is believed to help induce the production of breastmilk. *Hardi* is also the main yellow pungent "heating" ingredient used in the preparation of *halwa*--a special dessert made only during the *chatti* or *barahi* ceremony (Mahabir 1992b: 97-98, see Appendix D for recipe).

Though women of all ethnic groups take their first full-body herbal shower on a specified day, the bath obtained by Hindu women is more ritualized. The new mother sits on a stool or bench naked except for her underwear, and "faces" a cardinal direction (usually east) which the *pandit* has specified. The masseuse stoops behind her and holds her lower abdomen with both hands. Another woman pours seven or nine drops of the bathwater on the mother's forward-tilted head, allowing them to fall on her abdomen, and run down to the pubic area. The masseuse pulls the abdomen rhythmically and suddenly every time the warm water is poured from the cup. After the shower, the new mother is asked to stand. The masseuse stoops in front of her and holds both hips. She then presses her head against the lower abdomen and makes a raising motion with it in an effort to lift the "mattress" and womb which had dropped with the weight of her pregnancy. The motion also stimulates "bad and black blood to come down." The bath of the baby in warm herbal water also marks the day as the end of the period of confinement.

The masseuse escorts the new mother from the bathroom to the bedroom where she and her infant are massaged, and a new maternal abdominal binder tied. Mother and child are also changed into new clothes. The mother is then led outside the house to the yard where she is instructed to cover her head with an *orhanee* [veil], in obeisance, and hold her baby in her arms. She looks at the rising sun and expresses thanks to Surujnarine, the Hindu sun-god, and asks for his guidance and protection from sickness and accidents. At the end of her supplication, she bends and touches ("offers") the child five times to the ground, symbolic of Dharti-mata [Mother-earth], and to her forehead (Figure 6-5). Meanwhile, the masseuse sings excerpts of *bhajans* [hymns]. A *deya* [earthen lamp] is then lit with coals and jawine as

Figure 6-5 On the sixth day after childbirth, the masseuse (right) instructs the new mother to "offer" her baby five times to the ground, symbolic of *Dharti Mata* [Mother Earth].

fuel, instead of the usual cooking oil. The *deya* is placed on the threshold of the bedroom's doorway which is suggestive of the liminal status in being neither in nor out, clean or unclean, "betwixt and between" (see Van Gennep 1960:29). On re-entering through the doorway, the mother steps over the *deya* so that it is momentarily between her two open legs. She then turns it over with her right foot and smashes it. After, she goes inside the house to continue to participate in a series of other rituals to be performed later in the day.

As in Uttar Pradesh in the 1950s (Luschinsky 1962), much of the postpartum ritual activities in Trinidad take place inside the room of confinement during the afternoon, where invited guests cannot enter until the ceremony is over. The masseuse arranges seven paan (betel) leaves side by side in a row on a makeshift *bedi* [altar] made on the eastern corner of the room. The *bedi* is made of either a banana or sohan/kashebow/cascado leaf spread open on the floor. While singing *bhajans*, she instructs the new mother to offer oblatory drops of *haldi* powder, *sindaar*, rice, *roti* [Indian bread], *channa* and *aloo* [chick-peas and potatoes], *halwa*, *dahl* [split-peas], coconut oil, puncheon rum, pieces of curried home-grown chicken, and bits of other cooked food on each paan leaf.

Since rum and meat are considered unclean and polluting, the offering of meat is left to the discretion of the officiating masseuse, and drops of water and rum are poured on the side of the leaf. All oblations are offered to the female saint Parmaysee, whose arrival helped open the cervix for the baby to be delivered. The rum, however, is offered to a male patron, Dih Baba who is believed to be the spiritual landlord and gatekeeper of the household. A *tarta* [brass plate] is beaten vigorously with the belief that the child would grow up not being afraid of loud noise like thunder. The baby is also tossed

gently in the air by the masseuse and then placed in a large home-made tin scoop ("soop")--used for selecting bad grains and peas--and dragged throughout the house, indicating a wish that the child travels widely by boat or airplane particularly to United States of America.

After *puja* [devotion] is done, the new mother remains sitting on the *pirha* [low bench] and is required to eat as much as her "belly" could hold (see also Minturn 1963). She eats first in the bedroom, using one hand to hold the child and the other to eat, while guests, relatives and neighbors sit and chat outside. Bits of food are touched to the lips of the newborn to prevent him/her from growing up greedy. In the late 1950s in Uttar Pradesh (Luschinsky 1962), this same rite was interpreted to mean that the baby has now become *juta* [unclean] and, therefore, no longer attractive to evil spirits. As among Guatemalan Indians (Cosminsky 1982, see also McGilvray 1982) Hindu postnatal women take a small drink of rum to "cure" and 'heat' the strained "cold" reproductive system. The masseuse, as well as all the participating women in the confinement room, partakes of a drink from the circulating bottle to express her solidarity with the new mother.

In the room, a small fire is kept continuously burning to ward off evil spirits (see also Kitzinger 1995). *Kajal* [lamp mascara] is prepared by the masseuse, and is used in the baby's eyes and dotted on the forehead (*tika*) to protect him/her from the evil eye. *Sindoor* [vermilion powder] is also pasted on the front middle-path of the new mother's head, and on those of five married women whose husbands are alive (Figure 6-6). Unlike in Nepal (Reissland and Burghart 1989), the shape of the *tika* does not vary with the sex of the child. The *chatti*, like all other Hindu ceremonies, invariably involves family members of both spouses as participants and as guests (see also Levin and Idler 1981). The *chatti* reaffirms the need for gender, family,

Figure 6-6 On the sixth day postpartum, the masseuse (center) oversees that *sindoor* [vermilion powder] is applied to the forehead of the new mother (left) by five married Hindu women

and communal solidarity of the Indian community in the ethnically-competitive society of Trinidad. The exclusion of unmarried and widowed women from applying the *sindaar* is an archaic and patriarchal attempt to confine the sexuality of women within culturally sanctioned norms.

Guests arrive in the evening, and are served food and drinks by both men and women (see also Solomon 1990). The evening begins a long night of ribald rejoicing when *sohar* and *chutney* songs are rendered in Hindi and English or blasted from a stereo player. Again, the masseuse performs an important role as the lead singer and drummer or *dhantal/manjira* percussion player. Women perform gyrating dances using various kitchen items to symbolize the penetration of the penis into the vagina. Men are often excluded from witnessing this form of female entertainment (see Klass 1988). The new mother remains a passive onlooker, or may retire to her bed, but she is instructed to be awake until midnight when *Bhagwan* [the Supreme God] arrives to write the fate of the baby on his/her forehead.

Moore (1995:182) argues that the *chatti* ceremonies in neighboring Guyana

> reveal no evidence of cultural borrowing from the host society, and despite minor alterations they remained for all practical purposes faithful to Indian tradition. . . . Such changes as did occur were more related to a gradual process of syncretism among the variants derived from different parts of India, except where religion emphasized differences. Here too, therefore, the Indians were able to resist successfully . . . conforming to the dominant norms and customs of the of the cultural elites.

The same can be said for Trinidad. As among Guatemalan Indians (Cosminsky 1982), the frequency of the feasting element in the ceremony among Trinidad Hindus is declining. Many women mention that time and cost are the two major constraints in organizing the celebratory ceremonial feast. The *chatti* is now more confined to immediate members of the family

("just home people") minus the communal feast, dancing, singing, and the full repertoire of rituals. The decline corresponds with the diminishing adherence to, and belief in, certain rites and symbols associated with the ceremony. The joint participation of relatives from both sides of the family, nevertheless, emphasizes the importance of birth in continuing the family lines and cementing family bonds.

Summary

Of the 64 postnatal women I interviewed in Trinidad between June and September 1996, no one said that they were visited by a hospital district nurse with whom they could have discussed breastfeeding and other puerperal problems. The absence (or scarcity in other cases) of regular personal biomedical advice, therefore, nurtures the persistence of traditional health-care provision within the family during the puerperium. Precautions against eating certain foods, taking baths during a specified day, avoidance of visiting certain places, prevention from physically-demanding work, etc. are observed on the basis of tradition, and are reinforced by elderly grandmothers and folk medical specialists. The period of convalescence following delivery is approved by the biomedical practitioners I interviewed (n=30) because, among other reasons, it establishes the critical mother-child bonding (see also Fuller and Jordan 1981). In seclusion, the new mother has exclusive time to orient herself in getting to learn the significance of her child's movements, sounds, cycles of hunger and satiation, wakefulness and sleep, and excretory pressure and release. The focus on rest and the avoidance of being exposed to public eyes are being reinforced by the government of Trinidad in its bid to

introduce a law mandating that all working new mothers should be entitled to paid maternity leave (Owen 1997)

Notes

[1] The term *lamáyra* was commonly used by agriculturally-rooted villagers in Trinidad. Literally, it means a rice plant that has sprouted from fallen paddy during harvesting in the swamp.

[2] The terms 'hot' and "cold" do not refer to the temperature of a person or thing, but rather to the innate quality of foods, herbs and medicines, illnesses, mental states, and natural and supernatural forces. Substances are classified as "hot" or "cold" according to their effects on the body (Gonzalez-Stafford and Gutierrez 1983).

[3] Among Jamaican women, 'babycold' is a potentially crippling and sometimes fatal disease affecting the lower torso and legs. It is contracted by "open" mothers when exposed to "cold" (Sobo 1993:68). Springer (1979:47) argues that in Trinidad, it is only a very skilled midwife/masseuse, or someone with great knowledge of bush medicine, who can cure such a cold.

[4] According to Cosminsky (1982), one of the main functions of the bath in Guatemala is to warm and lower the breast milk.

[5] Even numbers (especially five, seven and nine) are symbolically significant in many rituals worldwide (see Foster 1953). The numbers recur in Hindu cosmology.

[6] Most of the postnatal women I interviewed could neither identify nor recall the names of the nine plants which were used as ingredients in the bathwater. This finding is consistent with that of Lachman (1987:78) in Guyana who found that "many of the younger people are not interested in learning about herbal remedies." The descriptions of the plants by masseuses and elderly grandmothers, on the other hand, are detailed and graphic. Kara keet, for example, is described as having "a stick kinda hard with a yellow and red flowers, and it does send out a seed."

[7] Brody (1985:169) writes that in Jamaica, women also regard plants with pronounced tastes and odors as physiologically powerful and as being able to produce good effects.

[8] Klass (1988) observes that in the 1960s in Trinidad some of the wealthier Hindu families preferred to hold the birth celebration on the twelfth day (*barahi*) which was of greater magnitude for reasons he did not specify

[9] Indo-Trinidadian masseuses believe that, in making any medicine in which milk has to be used as an ingredient, 'the pack milk wha they does sell in the grocery is good, but the cattle milk is better'

CHAPTER 7
CARE OF THE NEWBORN

Since district nurses hardly--if ever--visit new mothers after hospital discharge in Trinidad, the main personal advisory system available after postnatal discharge is to be found among village and family networks (see also Morley 1978, Staker 1992). The presence of a grandmother and masseuse plays an influential role in the behavior of a postnatal woman, and in the care of here newborn infant. Most women claim that belief influences practice and, hence, outcome:

> Nothing would happen to you if you did not know, you see you [were] innocent. If you know something was wrong, and you do it, then it would affect you.

Particularly in orthodox Hindu extended families, the father may not even have contact with the mother or child during the recovery period. Postnatal women in nuclear families suffer from the loss of emotional and physical support during the puerperium. In this context, therefore, Indian women are generally better cared for by immediate relatives and/or masseuses to whom they can relate. Even when masseuses are of African descent, their adoption of traditional Indian medical concepts like *jharay*, *sakay* and *hassuls*, make them appear as part of the extended family. The neglect of elderly women as postpartum caregivers by the official health care authorities is unfortunate. Like breastmilk, they represent an important local resource that, if used, can benefit the economy medically, ecologically and economically.

Breastmilk

The medical staff at Mt. Hope Women's Hospital encourages mothers to breastfeed as frequently as possible by using a variety of methods. Generally, bottles and formula are never given to mothers who are roomed-in with their newborn infants in the postnatal ward. As seen in Chapter 4 (Figure 4-1), ward nurses give the most information on breastfeeding than on any other postpartum subject. They emphasize that breastmilk is superior to any substitute, and should be given exclusively to babies. This advice is really a reinforcement of the information counseled to them during their antenatal visit to their respective district health centers. Displays of milk formula, or any other forms of advertisement on the ward, are also prohibited. A visiting nurse from Johnson and Johnson distributes free samples of all maternity and baby products except powdered milk. However, one local pediatrician (Ockille 1996a:13) has accused "most doctors in the country [for being] nearly as neglective of breastfeeding today than they were 40 years ago." He adds that they are "guilty of not getting the message across to mothers that human milk is the best milk for their babies." The reason for this reported attitude is based on the fact that medical practitioners depend on formula companies for sponsorship and research grants. Moreover, some doctors own shares in local infant formula distribution companies and retail outlets (particularly pharmacies) that market breastmilk substitutes. The result is that Trinidad imports about US $1 billion, or 380,000 tins, of infant powered milk per year (Ockille 1996a:13).

Parturient women are told in both the ante-natal and post-natal clinics that breastmilk is manufactured from what they eat, and that they should consume enough protein, vitamins and fluids (see also Leach 1983, Zephirin

1990) A diet rich in calcium, iron and Vitamin A, found in foods like green leafy vegetables, *bhaji* [spinach], callaloo liver, cheese, carrots and pumpkin is recommended to satisfy thirst and to replace lost fluids. Lactating mothers are urged to increase their intake of fluids with soups, broths, porridges, *dahl* [boiled split-peas] coconut water and milk. The advice given by the postnatal hospital nurses to drink a regular supply of milk while breastfeeding confirms the traditional belief of new mothers that they do not have the innate capacity to produce milk daily, and they, therefore, need "help." Indeed, the 74 percent of women who breastfeed--whether in-part or exclusively--consume a larger-then-normal amount of Nestle's 'pack milk' during the puerperium. Unlike their counterparts in South India who consider milk to be 'cold" (Ferro-Luzzi 1974), Trinidadian Indian postnatal women consume milk and milk products, to help maintain a sufficient energy level and encourage the production of breastmilk.

Of the 58 mother-infant dyads I investigated, only 12 (21%) women were breastfeeding their newborn infants exclusively. Thirty (53%) were giving both breast and bottle, and 16 (26%) were feeding their one-month old baby with the bottle only. In the latter category, three of them suffered from inverted nipples. There were no marked differences among women of various racial and ethnic groups. There was also no difference based on the age of the mother, or the sex of the child. The results of a survey (Rampersad 1989b) conducted in Trinidad in 1987 show a larger percentage of younger and more educated women were breast-feeding than their older and less educated counterparts. The results also indicate that the "intensity' of breast feeding had generally declined due to the introduction of supplemental foods long before breast-feeding was stopped. The decline was believed to be related to the increase in the participation of women in the paid labor force during the

oil boom in the 1970s The shift towards bottle-feeding in other countries has been attributed to urbanization and industrialization (Katchadourian 1987), the indiscriminate use and promotion of infant formula, the lack of a national policy on the promotion of breast-feeding, and the inadequate support for women in health care institutions, the work place and the community (TG 1995)

Despite the best efforts of the nursing staff in Trinidad to convince new mothers that they have the capacity to sustain exclusive breastfeeding for at least four to six months, eighty percent of the women I interviewed (n=64) believe otherwise Indian as well as African mothers believe that their milk production is insufficient to meet the constant demands of their infants. "It wouldn't keep them up" They are convinced that the baby does not get enough breastmilk and they, therefore, have to resort to complimentary feeding. One 34-year-old mother of a male infant expressed a common sentiment

> I try to breastfeed him only but apparently his belly doesn't be full. The nurses in the hospital advise[d] us to breastfeed, but he cries regularly after breastfeeding Then I started to give him the bottle He cries soon after breastfeeding compared to bottlefeeding. Instead of the four hours break after bottlefeeding, he cries for feed two hours after breastfeeding.

Some women were concerned that their babies were "so big" compared to the size of their breasts, and expressed the need for "help" One 27-year old Spanish mother said:

> Even when he was in the maternity hospital, he was drinking three ounces already. After he take the breast, he still will take the bottle with the required ounces The breast alone does not satisfy him. You would just done nurse him, and a little while after he would start to cry When I give him the bottle, then he would quiet down.

None of the anxious low-income mothers in the sample had a set of baby scales to determine the quantity of breastmilk taken after a feed (see Valman 1980) Physicians I interviewed (n=30) argue that most of a newborn s feed is obtained within the first 3-5 minutes. Therefore, the length of time that the baby is on the breast is not proportionate to the amount of milk the baby receives They also maintain that frequent breastfeeding stimulates increased lactation, and that the cry of a breastfed infant is likely to be due to other reasons, because a breasfed baby is always satisfied (see also Chamberlain 1984) They agree, however, that factors like fatigue, worry and illness can temporarily lessen the supply of milk in the mother (see also Leach 1983 Spock and Rothenberg 1985) Biomedical research (Zephirin 1990) has shown that even inadequately nourished mothers provide milk of sufficient quantity and quality, although the vitamin levels may be low if the mothers themselves are vitamin deficient

Physicians argue that the size of a mother s breasts has no relation to the capacity to produce milk. "Since the only purpose of the tissue is to encase and protect the more functional elements of the breast, it has no bearing on a mother's ability to produce and give milk" (Gibbon 1996:2) None of the women interviewed admitted that they turned to bottlefeeding because of the belief that the sucking motion would make their breasts sag instead of stand up. As in Jamaica (Sobo 1993) as well as in Surinam (Staker 1992), a dried-looking bosom is an indication of declining and unattractive physical condition Grandmothers and the masseuses, however, reveal that woman in their care have expressed the concern about how breastfeeding might make their breasts "look like ah ole woman." One 76-year-old masseuse was accusatory

> They lying when they say they eh [don t] have enough milk in they breast Well, if that is so, then drink milk or bush medicine In my days, my milk was running like a cow The baby couldn t drink all I had to throw way some in a fig [banana] root

Grandmothers and masseuses chided young mothers for being irresponsible. "They making excuse thet the milk wetting-up their dress" Elderly women disclosed that they had nursed their children until they became pregnant again

Mothers who practiced complimentary or artificial nipple-feeding gave other reasons for not "pushing" the breasts exclusively. Those who had to work outside the home after the postpartum period said thet they wanted the child to become familiar with the bottle. Others "practice" the child with the bottle in preparation for outdoor ("going out") feeding, citing discomfort in baring their breasts in public. ("I does walk with a bottle of tea [powdered milk]") Yet others claim that the baby frequently fusses during breastfeeding, chews the mother s sore or cracked nipples and pushes, or turns away from, the breast. ("I try but . . . she will suck the breast and spit out the milk back") Women who had undergone C-section surgery, or had suffered from inverted nipples, maintain that the neonate was already 'accustomed" to the artificial nipple from the first few hours of birth. Most of the mothers who practice mixed feeding offer the breast only during the night because of the convenience of the traditional co-sleeping arrangement

No one had a breast pump, and only six percent express their milk for storage in the refrigerator because of the belief that heated "cold" milk is not healthy for the child Mothers also claim thet the baby refuses to drink the breastmilk even when it is given in the bottle. "I try to give her in the bottle for a few days and she doesn t want it at all. She does vomit it out" Hospital nurses and breastmilk promoters maintain that new mothers are delinquent

in failing to feed their infants on demand, which is about every 2-3 hours during the first few weeks of life. They add that mothers feel fulfilled to actually see three or four ounces of formula (85 or 115 ml) vanishing into the newborn's small throat. They claim that once a mother perceives that her milk production is insufficient, she may stop breastfeeding completely. Spock and Rothenberg (1985:124) advise:

> Usually babies enjoy the bottle so much that they continue to take it and so have less appetite for the breast. Therefore, in most cases, the mother must deliberately cut down on the formula and count on the baby's increasing hunger to give more stimulation to the breasts.

Unlike African women in Haiti (Alvarez and Murray 1981), postnatal women in Trinidad never visit a pharmacy or doctor to seek a remedy to increase their milk supply. Generally, parturient Indian women use turmeric/wild saffron ("hardi"), while Africans use vivine/bovine herbs or wild coffee root boiled in water to increase the production of breastmilk (Figures 7-1, 7-2 and 7-3). The turmeric is ground, boiled with butter and sweetened to be drunk by the mother until the sixth day postpartum (Mahabir 1991). The stems and leaves of the vivine plant are boiled, and the water strained into a teacup. The brew is taken "plain" as water ("cooling"), or with a milk additive twice daily during parturition (Springer 1979:46).[1]

Some women also place a hot towel on the breast to melt "hard milk." Indian women comb the long tresses of their hair in a downward motion over the breast. Massaging and applying warm compresses to treat engorgement caused by clogged ducts are recommended by the biomedical community (see Gjerdingen 1993). A 91-year old Indian masseuse prescribes a brew consisting of ground ingredients like jawine, the black-colored mangrail,

Figure 7-1 Hardi/turmeric plant used mainly by Indian women to increase breastmilk production

Figure 7-2 Vivine/bovine plant used mainly by African women to increase breastmilk production

Figure 7-3 "Spanish" woman with a wild-coffee plant rooted out from a nearby abandoned plot of land.

harey kalanimack hing, muraa ("a kind of ring-up wood"), pipal seeds turmeric, ginger, and ghee [clarified butter] boiled in cow's milk. One teacup of this concoction is drunk until the sixth day postpartum. The massaging of the breasts by Indian women during the confinement period is also done with the intention of stimulating milk production ("bringing down/out the milk" or "filling up the breast"). Thus traditional practice is recommended by childbirth advocates (e.g. Leach 1983, Stoppard 1994) to relieve the pain of hard sore lumps and blocked milk ducts in the breasts.

When a child has stopped breastfeeding completely, or in the case of infant mortality, traditional methods are used to help suppress the milk. Lactating women of all ethnic and racial groups either squeeze the milk over an ant's nest, or over burning coals in a fireside. They also drink boiled leaves of "heated" plants like sitament/bay leaf to "dry" the milk. Agriculturally-rooted Indian grandmothers and masseuses make a necklace of dried corn grains which they string around the neck of the woman. Doctors prescribe the drug bromocryptine to treat this condition (see Adamson 1983).

Forty-six (80%) of the mothers I interviewed bought imported infant formula from the stores, and only five (9%) made their own complimentary artificial feed at home. The latter were mainly very-poor women of all racial and ethnic groups. The porridge ("flour pap") is made at home with flour parched ("burned") in an iron pot "to take out the heat." Uncooked flour is believed to be a "heated" food, which if used "raw" in any kind of infant feed, can cause the baby to get a skin rash. Another method of preparing the porridge is by boiling one pound of flour tied like a ball in a piece of cloth. When cooled, the flour-ball becomes hard like chalk, which is scraped with a knife or grated to make it in a powered form. The unused portion can be stored in a tin pan for a few weeks. Both parched and boiled forms are mixed

with other types of commercial powdered milk to give the baby sustenance. Brown sugar is recommended as an additive because it is felt to be more "wholesome" than the white variety.

Mothers and grandmothers observe that when the neonate is fed with the breastmilk he "still want[s] more, still want[s] more," while the porridge has the desired effect of putting the baby to sleep comfortably "because the child belly full" (see also Alvarez and Murray 1981). The children are expected to "strive better" and grow up being, and looking, "tough." Grandmothers lament the absence of arrowroot--an equally satisfying baby food--from the shelves of the local shops. These were once imported from the neighboring island of St. Vincent. Before the 1960s when the majority of Indians were cattle-rearing rural dwellers, cow's milk was considered the closest substitute to human milk.[2] For Hindus, the cow is revered as a "mother" whose nine-month gestation period is the same as a woman's.

Partly as a complement to the breastmilk, all the women in my sample administer a few ounces of boiled water daily to their newborn infants with a spoon or bottle. Water is fed to prevent constipation-- especially if the baby is using a formula--and as a "cooling" to deter the incidence of skin rash ("heats"). It is also administered to dilute the perceived salt-content of the "tin milk" which can lead to the drying of the baby's skin and stool. Medical practitioners are divided on the need for the baby to be fed water (see also Ockille 1996b, Spock and Rothenberg 1985). Seventy percent argue that the amount of fluid in the breast or formula is naturally calculated to satisfy the baby's ordinary needs. Thirty percent say that the sometimes-excessive heat in tropical Trinidad (approx. 90° F.) requires the intake of water.

As in Haiti (Alvarez and Murray 1981), Trinidadian women, both old and young, seem unanimous in their view of the superiority of breastmilk to

powered milk or cow's milk. They believe that breastmilk has healing properties not only for the child but also for any person afflicted with skin rash or eye complaints. Parturient women are taught by child health-care practitioners that breast milk is filled with protective antibodies that can either fight or kill invading bacteria, viruses and other disease-causing organisms, and can greatly reduce the impact of most illnesses in newborn infants (see also Gibbon 1996). They are told that breastfed babies are less likely to suffer from intestinal infections, like gastroenteritis, and respiratory diseases, than artificially-fed infants.

Nurses, grandmothers and masseuses believe that the anti-infective properties of breastmilk can be applied in the treatment of sick eyes. While being discharged from Mt. Hope Women's Hospital, nurses instruct women to use breastmilk in the eyes of their newborn if they appear to be "sticky". Grandmothers and masseuses prescribe two drops of breastmilk to be used twice daily in the eyes of any person suffering from eye-colds, "running eyes," eye "lash," pink/red eyes or poor vision (Springer 1979:46). They say "it better if you spray it straight and hot just so" instead of using a spoon or eye-dropper. Many people vouch for its effectiveness, claiming: "It does help it does really clear it up." The breastmilk of a woman who has given birth to a son is believed to be more effective. Again, preference for, and superiority of, males are culturally constructed in this traditional medical system. The Hindu obsession with the pollution expresses itself in the emphasis that the lactating woman must be "clean," (i.e. after 21 days postpartum, she must take a bath and abstain from sex) before offering her breastmilk as medicine.[3]

Slightly more Indian than African women (55% vs. 45%) squeeze the breasts of newborn infants to release milk. Again, the presence of an elderly person in the home during the postpartum confinement contributes to this

knowledge and practice It is quite common for the breasts of a baby to enlarge and even for a few drops of milk to be formed, towards the end of the first week of birth. The enlargement may be asymmetrical (Illingworth 1988, Jelliffe 1968, Milner and Herber 1984, Spock and Rothenberg 1985, Valman 1980) The infant's puffed-up breasts are due to milk-forming maternal hormones (estrogen and prolactin) passing from the mother's blood to the fetus's during the last few days of pregnancy Biomedical practitioners strongly advise mothers and home health-care providers to leave the swollen breasts ("neonatal mastitis") alone, as they would subside spontaneously Massaging or squeezing is likely to irritate and infect the palpable breasts which become painful and inflamed, and would have to be treated with antibiotics like penicillin. Women I interviewed squeezed the nodules ("seed" or 'bumb') of male infants 'to get flat' and to thwart "the breast from getting big like a woman when they grow up' The nipples of female infants are also squeezed to prevent pre-mature breast development and stomach aches

Neonatal jaundice

Jaundice is clinically described as a symptom, not a disease, characterized by a yellowish discoloration of the eyes, skin and nails (Jelliffe 1968, Nathanson 1994, Ross-Perot 1996) The symptoms are sometimes difficult to identify in dark-skinned children (Morley 1978) Jaundice occurs more often in newborns mainly because of the immaturity of the liver, the normal breakdown of red blood cells, and the subsequent increase of yellow molecules called bilirubin. The level of bilirubin in the blood of newborns is normally higher than that in older babies and adults After birth, the child's intestines continue to recycle the bilirubin. But since they do not have the

placenta and mother to get rid of it any more, it stays in their own blood When there is an excessive amount, the bilirubin backs up in the blood stream, seeps into the skin, and the baby turns yellow Nearly all babies from about three to ten days old have some degree of jaundice, or yallowness of the whites of the eyes and the skin. Early jaundice, which occurs within 24-48 hours of birth, is usually due to abnormal haemolysis, infection, or bruising from birth trauma Jaundice generally occurs in 25 to 50 percent of all normal newborn infants, and a considerable higher percentage of premature newborns (PSTT 1992.15) It is the only time in life that jaundice can cause severe neurological or mental handicap (Thomas and Harvey 1994)

Pediatricians use either phototherapy or exchange fusion as two relatively safe methods of treating neonatal jaundice In phototherapy, the child is placed naked under a light with eyes and genitals protected The light breaks down the bilirubin in the skin into a non-toxic form which is excreted in the urine In exchange fusion, the jaundiced blood is removed from the body and replaced by normal blood units (PSTT 1992) Postnatal nurses at Mt Hope Women's Hospital instruct departing mothers to walk the infant in the early morning sunlight daily to prevent the onset of neonatal jaundice It is a common sight in Trinidad to see mothers walking the streets on mornings with their babies as part of a long-established folk medical tradition. "I hear the ole people say that the child need[s] a little fresh air You can't keep a child coop-up in the house all the time. Women both old and young, also claim that the sunlight makes the baby's bones grow stronger, the skin "get a nice color, and the baby generally thrives ("strive") better For Hindu women, the sun is a manifestation of Sun-god Surujnarine, the source of all light and life, before whom *jal* [water] is usually offered on the family shrine at sunrise.

Hindu women, and sometimes women of other ethnic groups, visit the masseuse a *jharay* [ritually treat] jaundice. Hindu priests, who are exclusively males, and usually of the high brahmin caste, do not *jharay* jaundice. They consider the process to be polluting and, more suitable for a woman to treat. *Jharaying* would be a preclusion to the performance of ceremonies for which they are paid. Hindu priests refer visiting patients to village masseuses, and also recommend that the child be walked in the sunlight (see Phillips 1996). Woman seek the help of a masseuse as a source of an alternative as well as a complementary form of healing.

Masseuses treat jaundice by chanting a mantra and stirring a bunch of doob grass, tied like a broom, in a *tharia* [brass plate] filled with mustard oil and water. An adult patient is instructed to place the fingernails of her hands in the mixture while being seated on a chair or bench. In *jharaying* neonatal jaundice, the heels of the newborn are placed inside the yellow liquid. The process is repeated for several days during sunrise and sunset. Non-medical observers claim "In front of your eyes you could see the jaundice coming out, and the oil turning yellow." This therapeutic ritual is sometimes performed on patients warded in the hospitals in Trinidad in the presence of biomedical health-care providers who tolerate the practice. They naturally dismiss this form of therapy as "superstition" which shoule be abdndoned in spite of a shortage of phototherapy units in the country (Ross-Perot 1996). Doctors argue thet the most common form of neonatal jaundice ("physiological jaundice") disappears on its own without the need for any kind of ritual or medical intervention. But doctors seem unable to explain the disappearance of "yellowness" in the skin of adult patients.

Non-Hindu traditional health care providers prescribe the use the "Man-better-man" plant for jaundiced adults. The leaves are boiled and

drunk twice daily as tea, the rest of which can be stored in a refrigerator African grandmothers and masseuses instruct non-Indian parturient women to avoid eating curried foods. Masseuses of all ethnic groups advise fertile women engaging in unprotected sex to take regular purges to clean out the system as a prevention against neonatal jaundice Purgatives may take the form of a concoction of lamp oil, bitter payee, caraille, soursop, and hog plum plants One or two leaves of the hog plum plant should be decocted ("draw it) while other plants should be boiled Only half of a teacup should be taken because the potion is believed to be 'strong"

Dew and Evil Elements

Meteorologists in Trinidad and elsewhere (e.g Dobson 1968, Meteorological Office 1962, Trewartha 1968) state that on a clear night the ground temperature falls because of the continuous loss of heat by long-wave radiation When moist air comes in contact with cool surfaces near the ground, the air may be cooled to the point where its capacity to hold water vapor is exceeded by the actual amount in the air Dew is produced when water vapor from the surrounding air condenses into liquid form on cool exposed objects at or near the ground

Low-income Trinidadians of all racial and ethnic groups believe that the postpartum is most vulnerable period for the mother and her neonate and they, therefore, must be protected from harmful nocturnal "outside" elements. One such element is the 'cold" dew which is believed to be falling consistently from the sky throughout the night like a "slight" drizzle The new mother and her child remain secluded during the night and avoid being exposed to anyone entering the house "with dew" (see Klass 1988 119)

Accordingly a rule is established in almost every family that anyone approaching the house after six o clock/dusk must remain in the porch ('gallery') or garage for five to ten minutes to "cool off" or "breeze off" before entering the room of confinement. Some rules stipulate that the entrant should even change his dew-infested clothes before coming in contact the baby as a precaution against the child falling sick with dew."

One symptom of dew illness is manifested in the yellowish green color of the fresh -smelling diarrheal stool. The illness, like gastroenteritis, is thought to be so virulent that it can render a child fatal. As a preventative measure against dew illness, a defecated diaper of the child is thrown on the roof of the house to "beat" or "face the cold" harmful elements of the rain and the dew. Even young mothers observe this practice because "the older people does say so, you know, and [we] just follow it up." Some women do not believe that this practice is a remedy, but they admit that "it helps." Others testify that the tradition has practical validity: "It is a true thing; it is a true true thing." Only 20 percent of the women in the sample do not observe this practice, most of whom were living either in a nuclear or female-headed households without the presence of an elderly female.

Masseuses, grandmothers, and mothers believe that exposure to dew is one of the main causes of infant gripe or colic. Another cause is the gulping ("pulling") of air by newborns when their mothers accumulate "wind/gas" in their empty stomach, or when they have insufficient breastmilk. "Wind" or "gas" may also gather in the stomach of infants if they are not being fed on time. Some mothers also believe that when infants are taking the breast or bottle, they unavoidably suck air between gulps, which later affects their stomach. The excessive air/wind/gas burns the young stomach, and if not

expelled by burping, turns into gripe. One 25-year old Pentecostal Indian mother said:

> Actually, I see it happen with him. When he was about a month old, he was only bawling and only wringing up like if something was wrong with him. My mother-in-law tell me he had gas in his belly. He was only crying crying like if he wanted to burp all the time.

Other causes of gripe are ascribed to the eating of hot peppers by lactating women, the excessive use of carbonated beverages ("sweet drinks") and "sour" fruits, and the consumption of curried food by non-Indian mothers. Pedistricians, however, admit that they cannot identify the cause of the complaint (see also Leach 1983). The condition is recognized by home-care providers, as well as doctors, when infants draw their legs up against their stomach, clench their fists, and scream paroxysmally on evenings. The abdomen is also usually distended and tense ("stiff"). Illingworth (1988:38) writes that during the two-to-twenty minute attack, "one may hear loud borborygymi, and much flatus is passed per rectum, giving temporary relief."

Physicians treat gripe/colic by prescribing Dicyclomine hydrochlorine (Merbently) which is an anti-spasmodic drug, though there is no evidence that spasm of the gut occurs in this syndrome (see Valman 1980). Family health care providers treat the complaint by using the leaves of the mint and lime plants the flowers of the pumpkin tree, and by the administration of Gripe-water and *ghoati*. Young mint leaves ("baby mint") are often bought in the open vegetable market and are decocted to make a drink which is fed to the newborn. A teaspoon is administered to cleanse and soothe the baby's stomach, which has be made "sour" with the frequent consumption of milk. In this mint brew, two young leaves of the lime ("lime bud") or soursop tree are added to help the baby sleep soundly. While Indian women treat gripe by

squeezing the mature flowers of a pumpkin plant around the navel three to four times per day, Africans rub red lavender oil around the navel.

Some Hindu masseuses, on the other hand, treat gripe by administering *ghaati* which is prepared by soaking asafetida ('hing'), rock salt ('kalanimack'), and ground nutmeg and haray [a seed found in massala] in breastmilk. The mixture also helps infants to "pass out wind" freely, makes them defecate ("go off") without discomfort, and assists them in sleeping soundly. *Ghaati* is believed to be more effective than the popular Gripe water--the positive results are seen just after two doses twice per day. When all the home-remedies are tabulated, it is found that the yard-grown lime buds are the most frequently used medication (36%), followed by proprietary gripe water (20%), mint (16%), red lavender (12%), pumpkin (8%), and ghaati (8%) (Figure 7-4).

As a preventative measure against the 'wringing" gripe symptom, the baby's diapers are not wrung by hand while washing, but are squeezed instead before they are hung to dry in the sunlight. This practice has almost disappeared with time, because most mothers use disposable diapers nowadays. Since mothers of all racial and ethnic groups maintain that the source of pain of gripe is centered in the stomach, they provide temporary relief and warmth by placing the child's naked stomach against their abdomen.

The night is believed to unleash not only harmful elements like the dew and cold, but evil spirits as well. For this reason, all late-coming entrants to a newborn's house are required to cross the threshold of the doorway while walking backwards after "cooling out" in the porch or garage ("That person could bring in jumbie that could hamper the child" and "Any thing could follow that baby after hours"). Additionally, antrants are advised to hold

children in their arms with their faces turned forward instead of backward As a precautionary measure, Hindu mothers perform "*totka*" before entering their houses after hospital discharge or during the night (see Vertovec 1992) In this ritual, five pebbles are collected from the yard and rotated around the child with the recitation of a mantra (*ounchay*) The pebbles are then thrown in different directions as an obstacle to any evil spirit stalking the newborn. Crying facial motions or sudden startles ("jumping") of sleeping children are taken to mean that an evil force is hovering over them As in Martinique (Horowitz 1967), people born with a caul ("veil") over their eyes are believed to have the power to actually see such spirits.[4]

The attack of an evil spirit stalking an entrant can severely affect the health of a child, the outcome of which can be fatal. Symptoms of spirit attack are felt immediately when the child suddenly begins to "scream, scream, scream for nothing, all the time" It is believed that only the recitation of prayers, and the attachment of a magical sachet, can dispel this evil force Women of all ethnic groups make sachets with indigo blue, camphor,[5] garlic, a ten-cent coin, and a written prayer, as the main ingredients.[6] Like low-income mothers in Jamaica (Henriques 1968), Trinidadian women also add asafetida ("hing") to the tiny blue or black cloth-bag The talisman ("guard" or "pocket") is then fastened on the inside of the vest of the baby (Klass 1964, Springer 1979) Additionally, an open Bible, a pair of tiny scissors, a closed penknife, or a box of safety matches is placed under the baby's pillow as a precaution against evil molestation. Infants of all ethnic groups also sleep in the same room (and often bed) with their mothers with a small bulb/light burning

The magical sachet is also worn as a charm against the evil-eye ("*mal-oje*") (see also Foster 1953, Nash 1967, Wagley 1967) It is commonly believed

by low-income Trinidadians that certain people, especially women, possess the power to inadvertently inflict harm, and even death, upon a child, plant or animal by merely admiring or touching the object of affection (see Ramnath 1987). If known, such persons are looked upon with awe rather than anger. It is no fault of their own that they possess "bad-eye."

> Not to say they jealous of something . . . a lot of people just have bad-eye you know. They just gaze at you baby and say, O Gosh, this baby so fat and chubby, and he so white, and he so nice. They don't mean anything bad. And after, you baby get sick. . . . I see that many times.

The offending woman may even sympathize with the afflicted child, plant or animal after an evil-eye has been cast and ill-health results. A person who becomes affected with an evil-eye cannot afflict or infect others. Such spiritual abnormality is believed to be congenital. Indeed, a mother can render her own child a victim if she herself possesses the evil-eye. ("The mother find the child too nice.") As in India (Jaggi 1973), the most dreaded carrier of an evil-eye is considered to be a barren woman, whose envious adoration is believed to be potent enough to kill a newborn within twenty-four hours.

Spiritual Baptist grandmothers identify two varieties of *mal-oja* in Trinidad based on the symptoms. They are "the crying kind" and "the shitting kind." The latter is the worse and is diagnosed when the diarrheal stool is found to be watery, greenish and foul-smelling ("high"). These grandmothers claim that some caregivers can easily mistake the texture, color and odor of the stool of a child suffering from the evil-eye as a symptom of gastroenteritis—as physicians often do. Other symptoms of infant "bad-eye" are fitful sleep, fever, vomiting, and ceaseless crying for no apparent reason.

> The child go bawl, the child go bawl, and it wouldn't take the breast and it wouldn't take the bottle. And doctor wouldn't know the cause. Even after the child take the doctor' medicine, she will still be crying crying crying.

Children are diagnosed with the malady when their eyes look weak their eyebrows stand straight ("raised"), and by other methods based on various traditional ethno-medical techniques

Spanish and Spiritual Baptists practitioners treat and diagnose the evil-eye by placing a branch of sweet broom in the patient's hand or on his chest. If the branch withers ("droop down/quail down") after a few minutes, the condition is ascribed to the malady (see Simpson 1962.22) To "cut" the *mal ojo*, prayers are recited over the patient, and holy water are sprinkled with the broom over the child A bath is also given with water, in which indigo blue and sweet broom are doused, and in which a few drops of lime are squeezed Additionally, a tiny piece of indigo blue is grated and put into a teaspoon of expressed breastmilk. These preventative and curative measures are more durable than the bag-sachet which may get wet or be forgotten in the baby's laundry

Hindus cure *mal-ojo* ("*najar*") by using the traditional Indian therapeutic rituals of *jharaying* and *ounchaying* (see Lambert 1992, Niehoff and Niehoff 1960) *Ounchaying* is done by any "clean" woman who takes a punch of salt, nine bird peppers, nine grains of clove, the skins of a garlic and an onion, seven pieces of a coconut-broom stand, seven dirt-pellets, and some grains of mustard seeds if available. The ingredients are bundled in a piece of paper and circled seven times in a clockwise direction over the baby The practitioner recites any known *mantra* and ends with a plea to the divine deity to cleanse the evil infection. The bundle is then burnt in a fire(place) against which the caregiver must turn her back after lighting It is the odor of the burning bundle that is the test to ascertain whether the evil eye has been destroyed or still active If the scent is fetid, the malady is destroyed One 54-year old grandmother revealed:

> If you burn the bundle otherwise, it wouldn't burn completely and it wouldn t smell nasty I burn onion skin and these things already, and I know the smell. You could tell the smell different

As in India (Lambert 1992), *jharaying* (lit. to sweep) is done by exclusively high-caste male *pundits* and *sadhus* [Hindu priests and ascetics] during dawn or dusk. It is considered as a more superior therapeutic treatment than the female-performed method of *aunchaying*. Practitioners of *jharaying* recite mantras inaudibly, while gently stroking/sweeping the patient from head to toe nine times with two strands of a used coconut-leaf broom.[7] At the end of each stroke, they blow air towards the patient's body. If the broom strands grow beyond a five-hand length, the illness is diagnosed to be *najar* (Ramnath 1987). If after repeated ritual treatments, and the symptoms do not disappear, the patient is referred to a physician because the disorder is diagnosed as having its origins in the body rather than the spirit.

Another measure Hindu women use to prevent the contraction of *najar* is the application of a black dot-shaped pigment ("*tikka*") on the forehead of the child. Christian evangelist pastors on the other hand, do not believe in the evil-eye or in any preventative charm. One pastor and father explained:

> We pray on the baby and cover him with the blood of Jesus. We believe that prayer is strong enough to protect him from any harm or any evil. To believe in *mal-aja* is to believe in witchcraft. We do not believe in witchcraft in any form. To make and attach an amulet on the child is to put emphasis and trust on an object instead of God. We have faith in the power of prayer.

Yet the majority (85%) of evangelical women I interviewed confessed that although they do not believe in *mal-aja*, they use prayer as a precautionary and curative measure. "When you' children sick, you would want to try

anything to make them feel better' and 'These young people nowadays don't believe in these things until it happen to them." Accordingly, the majority of women of all ethnic groups in Trinidad wrap a black-beaded ("jet") bracelet on their baby's hand as an amulet. Some even make a blue sign of a cross on the sole of the newborn's feet, others pinch the baby secretly to cry when someone expresses admiration for the child and a few mothers fit the vest inside-out to help the child sleep peacefully during the night.

Thrush and Heat Rash

Low-income mothers in Trinidad recognize oral thrush as a superficial infection of white flecks occurring on the tongue, the inside of the cheeks and on the gums. It appears as white plaques which are sometimes difficult to distinguish from milk immediately after a feed. Thrush usually makes children's mouths sore, and infants show discomfort when they are trying to nurse. These symptoms are consistent with that learned by physicians (see also Jelliffe 1968, Leach 1983, Spock and Rothenberg 1985, Thomas and Harvey 1994). Family health-care providers in my research believe that thrush is caused by the accumulation of stale milk "not being cleaned off" on the baby's pink tongue. ("Even big people does have to scrape their tongue") Like clinicians, they also believe that breastfed babies are less likely than artificially fed babies to get thrush in their mouths, because the yeast which causes the growth of this fungus is inhibited by ascetic and lactic acids in human milk.

Mothers, grandmothers, and masseuses use a variety of liquids to prevent and treat thrush ("trash"). An end of the baby's clean vest or diaper is dipped in either honey, urine, water, an antibiotic-based medication, paregoric oil or glycerine, and used to gently swab the inside of the baby's

mouth. Thirty-nine percent of family caregivers use warm water, 23 percent use honey, 16 percent use pharmacist or doctor recommended antibiotics, nearly the same number (17%) use paregoric oil and/or glycerene, and five percent use the child's fresh urine (Figure 7-5). Almost all the mothers who use urine are very poor women, most of whom are of African descent.[8] Physicians say that caretakers should not 'wipe' the white flecks in the baby's mouth because this may cause the underlying skin to bleed slightly, look inflamed, and cause sores to develop. They recommend the use of a clean piece of cotton wool dipped in a solution of half teaspoon bicarbonate of soda dissolved in one cup of boiled water, which has been allowed to cooled. Another clinically-recommended treatment is the application of one percent watery solution of gentian violet twice daily to the mouth until cured.

Heat rash ("heats") is described by low-income Trinidadian caregivers as 'fine,' 'tinsy winsy," or "little" buttons appearing mainly in the folds of the neck, the inner crook of the arms, the trunk, cheeks, and diaper areas of the newborn. Although there is no consensus on the cause and treatment of this condition, most of the beliefs deal with the phenomenon of 'heat'. Causes of heat rash are ascribed to spilt breast milk on the baby's skin, stagnant perspiration, high atmospheric temperature, body heat generated by plastic diapers, the use of Chlorax bleach in the child's laundry, the use of powered milk, and the consumption of "heated" foods, like hot peppers and curry by the parturient woman. Treatments are variable, such as the application of petroleum jelly, medicated Amen's powder, and corn-based starch on the skin, and additives like baking soda and Savlon antiseptic in the bathwater. Only Hindu mothers apply *ghee* [clarified butter] on the skin twice daily.

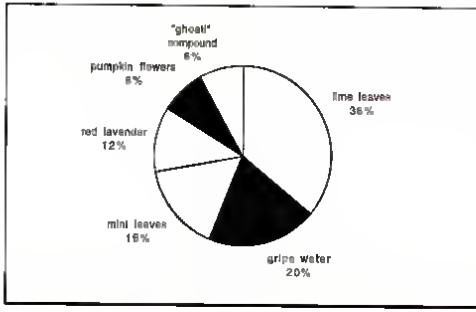


Figure 7-4 Frequency of home remedies used in the treatment of infant gripe/colic.

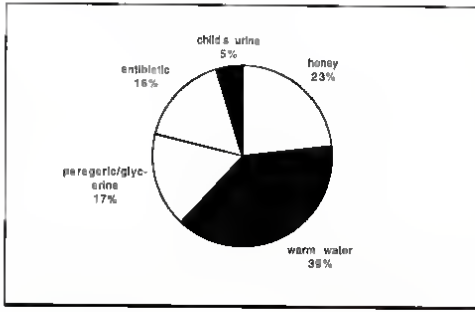


Figure 7-5 Frequency of modalities used (whether independently or combined) in the treatment of infant oral thrush

Biomedical practitioners explain that the skin inflammation ("miliaria") dotted by pinpoint blisters is caused by excessive prickly heat or thick clothing which results in the blockage of the sweat glands (see also Adamson 1983, Marshall *et al.* 1983) Infants are particularly prone to this harmless condition because of the immaturity of their skin structure. Physicians state that there is no specific treatment for heat rash, but they recommend the wearing of porous, nonbinding clothing; the application of a soothing lotion, powder, greasy ointment or vaseline, the taking of cool baths, and the avoidance of direct sunlight.

Infant Massage

Indian women in Trinidad do not only massage their infants more frequently than their African counterparts (92% vs 67%), they also massage them with more vigor and thoroughness. African women who are/were living among or near Indians are more likely to massage their children. The general regularity, however, was noted by grandmothers and masseuses to have declined among mothers of all racial and ethnic groups. They explained this phenomenon by saying that more women today are employed in the paid labor force, and they do not have the time to spend with their young infants, "It is only if they have an old mother or old mother-in-law that the child would get rub twice a day, every day."

During the postpartum, the masseuse or grandmother demonstrates to the new mother how to massage her infant. The massage begins with the woman seated on the floor with legs outstretched. The baby is alternatively placed on his abdomen across the woman's thighs. He is then turned on his back and placed parallel to, and on, the woman's closed legs, with his head

supported by the woman's insteps This position allows maximum body manupulation and is safer than on the bed where the baby may roll off and injure himself. Unlike in India where mustard oil (Luschinsky 1962), sesame oil (Nichter 1989), vinegar, and other turmeric-based ointments (Reissland and Burghart 1987) are applied, Trinidadian women use petroleum jelly, Johnson's baby oil or coconut oil. Home-made coconut oil is preferred to the store/market-bought variety which is likely to turn rancid. After the child is about six months old, massaging with a mixture of oil and brandy is believed to add strength to infant's bones and joints, and enables them to walk earlier and steadier.

As in India (Dash 1992, Johari 1984, Reissland and Burghart 1987), the whole body of the child is lightly massaged and then each part is given specific attention. The masseuse or grandmother dips her fingers into a cup of oil and allows a few drops to fall across the buttocks of the newborn. The buttocks are massaged in a "upwards" motion in an effort to "raise" them into shape. The limbs are "stretch[ed]" and "exercise[d]" in a yogic manner by pulling and criss-crossing them over the torso (Figures 7-6 & & 7-7) To instill fearlessness and to improve strength, older babies are gently swung and shaken by the arms and legs and thrown into the air in exactly the same way as described by Reissland and Burghart (1987 232) in India.

> The mother, taking the baby by the head and neck holds it in the air and lightly swings the torso back and forth. Then the baby is held aloft by the ankles and swung back and fort, upside down Finally, the baby is cradled in his mother's arms and then tossed about six inches into the air five times Thus part of the massage does not start until about ten days postpartum. As the baby grows older, the swings become exaggerated and the height to which the baby is thrown increases to about a foot and a half

Figure 7-6 A masseuse treats *hassuli* [clavicle dislocation] at her house by rubbing the affected area

Figure 7-7 A Indian masseuse does criss-cross yogic limb manipulations to an infant

One or two drops of oil are poured into the ears, navel and genitals as a cleansing and lubricating process.

After the massage, the baby is fed and placed in a hammock made from an empty rice bag strung with ropes from the rafters of the roof. The rhythmic swaying of the hammock and the "fresh" post-massage feeling combine to quickly help the baby sleep long and deep. Elderly Indian women and masseuses recommend massaging the infant twice daily until the child can walk firmly. Massage is also believed to make the baby "strive better," make the bones harder and stronger," and the "toughen" the skin, thus promoting early creeping and walking. Additionally, massage is thought to "open" the veins of the infant and allow the blood to flow freely. Children who are not massaged are thought to be soft ("sofee sofee"). Stretching is done to 'straighten' the legs and hands from the folded- and bowed-looking intrauterine postures. As is thought in Guyana (Fredericks *et al* 1986), and Jamaica (Sobo 1993), body manipulation of the tender anatomical structure is also believed to prevent a baby growing up with "bandy-leg," "long-head," and flat, broad nose," "push-out navel," and from suffering from the pain of a dislocated collar-bone. Forty-four percent of the physicians I interviewed did not know the clinically-tested benefits of infant massage (see Conclusion).

Regardless of their religious denomination, all Indian mothers and caregivers blow air from their mouths into the foreskin-opening of the penis of the newborn during the massaging sessions. Twice daily, the caregiver opens the ends of the prepuce into a circle, shakes a drop of coconut oil from her fingertip, and blows air into it. The air makes a whistling sound and rouses the baby to wriggle in discomfort. The penis is oiled and blown once every day to prevent the closure of the tip of the foreskin in non-circumcised male infants ("I do thet to keep the hole clear"). It is also done to aid the

eventual separation of the foreskin and the gland, and to promote the early retraction of the foreskin. This is done from the day the infant is discharged from the hospital until he grows up to be about one year old. Physicians advise that the foreskin should not be retracted. They state that since the penis and the foreskin develop from a single bud in the fetus, they are fused at birth and will gradually become separate during the first few years of the baby's life (see also Leach 1983, Spock and Rothenberg 1985).

African as well as Indian caregivers massage the nose of the newborn to shape it "narrow, straight and high" instead of broad, knobby and flat. Like their Jamaican counterparts (Sobo 1993:69), new mothers 'upraise' the nose-bridge to make it look more like the élite Caucasians, and to prevent it from appearing phenotypically Negroid (see Braithwaite 1975, Segal 1993).

Trinidadian family health-care providers of all racial and ethnic groups use cotton swabs soaked in menthylated spirit to treat the umbilical cord of the newborn (as instructed by the hospital nurses). They "clean the navel" gently with the swab, and dust it with baby a powder to promote spontaneous separation which usually occurs in about seven to ten days. The powder (often mixed with boric powder) keeps the stump dry and prevents it from smelling foul. After the cord has fallen off and dried, African women wrap the baby's abdomen with a cotton diaper for a few days to prevent the navel from 'pushing out" (see Springer 1979:46). A piece of cotton covered with a five-cent coin is placed on the stump and wrapped. Hindu, Spiritual Baptist and Orisha elders recommend that the child's maternal uncle touch the protruding navel with his largest toe on entering the house. The concern of women is aroused by the sight of the navel sticking out when the baby cries, strains and coughs. African women believe that the application of a "belly band" on the child prevents 'air" from accumulating in, and enlarging the

navel. Hindu Indian women on the other hand, *sakay* the navel twice daily. This procedure is done by lighting a cotton wick soaked in coconut oil in a *deya* [tiny earthen bowl]. The pad of the thumb is dipped in the oil, held as close as possible to the flame, and then pressed on the stump gently four or five times.[9] Since Christian and Muslim Indian women associate the *deya* with Hinduism, they use the flame of a candle instead, to heat the cooking oil to prevent the navel from "raising up like a Negro."

Doctors maintain that gentle cleaning with a spirited swab is all that is required for the normal moist umbilical cord until spontaneous separation occurs. Treatment with any other liquid or lotion may cause bacterial infection and/or actually delay separation. Doctors also observe that the bulged navel ("umbilical hernia") is common among African infants of the Caribbean. They say it is caused by a slight weakness of the muscles in the abdominal wall which allows the contents to bulge forward. They advise that no treatment is needed as the hernia usually disappears spontaneously within five years. Strapping, therefore, is a waste of time and can be a hindrance to healing (see also Leach 1983, Thomas and Harvey 1994, Valman 1980).

All Trinidadian lactating women observe some kind of dietary restriction when the newborn's navel is not yet "cured." They are restrained from eating plants which have many roots, such as breadfruit, cassava, avocado, and egg-plant. Animals, birds and fishes that have "digging and scratching" tendencies, like pigs, crabs, home-grown chickens and cattle, are also avoided. It is believed that these foods would retard the curing, drying and dropping of the umbilical cord: "It would take longer to cure and would remain raw for a longer time."

The dried fallen umbilical stump is saved by women of all ethnic groups in Trinidad It is either kept among valuables in a closet, or buried near the root of a banana or mango tree in the yard Family health-care providers try to prevent this item from falling into the wrong hands which could be used to inflict spiritual harm on the child (Springer 1979, see also Cosmunsky 1982) Just as Snow (1993) found among African-Americans, Trinidadian women perceive the cord to be a dismembered sacred part of the child, and a symbol of the nine-month "connection" between mother and child in utero which must be treasured or buried safely One 23-year-old Anglican mother explained

> If you throw it away, it is like if you are throwing away the child. The navel string was the life-line between the mother and the baby when it was in the womb

Some Hindus dispose of the umbilical stump by casting it in a flowing river, symbolic of the sacred Ganges in India

It is only African masseuses and Indians in multi-ethnic Trinidad who recognize the culture-specific infant illness referred to as *hassuli* The symptoms are vomiting, persistent crying for no apparent cause, and the inability to 'pull" milk from the breast or bottle. Masseuses diagnose the condition by touching the nape of children s neck and clavicle, and observing them jerk and shriek. *Hessuli* is believed to be caused by the movement of infants themselves when they begin to raise and "twist" their heads, thereby resulting in "the neck bone sliding outa place." It is commonly caused by mishandling of infants when they are lifted by one or both arms only, usually by older inexperienced siblings Mishandling can also include the failure to support newborns heads by placing the palm on the nape when they are being held upright A fall from the bed or crib can also cause *hessuli* The

illness afflicts infants seven times until they are about six months old, and then it is finally cured

Hassuh is treated by a masseuse who rubs the entire body of the infant, and particularly the skin around the clavicle, scapula, neck, and arms The objective is to reposition the collar bone i.e "to pull it up back down into place" After a series criss-cross limb manipulations the masseuse returns the child to the mother to feed with the expressed assurance that the *hassuh* has been cured "The baby wouldn't have the pain again" A disappearing mode of the therapy for *hassuh* is the "rolling of the child' This is done when the masseuse requests the participation of the mother to stand and hold two corners of a folded bedspread The masseuse stands in front of the mother and holds the other two corners The baby is placed in the middle of the sheet, like in a hammock, and both persons maneuver their hands so that the baby rolls to and fro

A number of sources indicate that there has been a decrease in the incidence of *hassuh* over the years. Most masseuses explain this trend by saying that mothers are not touching, holding or carrying their young infants as often as before Additionally, more women work outside the house, and infants are often confined to cribs Some masseuses theorize that the lower fertility rate of women makes it possible to take better care ('handling") of fewer children. All masseuses, however, express impatience with mothers who rely solely on biomedical forms of therapy for every single ailment:

> Every week the mother running by doctor She complaining, "The child eh sleeping "The child have fever." "The child have pain" "The child crying." [Do] you think if a doctor can't cure you, he will tell you? He will eat all you money He would never send you by me. He would say, 'Them old woman eh [don't] know nothing'

Masseuses and Indian grandmothers say that *hassuli* occurs among African children, but it is not recognized by their often-laxed mothers who leave them to 'bawl down the place'

Physicians I interviewed (n=30) claim that therapeutic massage as a treatment for *hassuli* is a "most babaric" "gruesome,' and "cruel" procedure that is "totaly uncalled for" They believe that the condition is caused by a fractured clavicle which should be treated by placing the affected arm in a sling (collar and cuff), and administering pain killers, such as paracetamol or ponstan. The clavicle is the easiest bone in the body to break, and is also the easiest to heal. The pain usually lasts two to three days and disappears with or without treatment due to callus formation (see also Silver 1983) Doctors, however, concur with masseuses on the etiology of the condition.

Like their counterparts in India (Luschunsky 1962; Reissland and Burghart 1987), Indo-Trinidadian masseuses and grandmothers anoint the soft head of the newborn with coconut oil during the daily evening massage ritual Women of all ethnic groups attempt to mold the skull with their oiled palms "to make it round,' and to promote the closure of the cranial sutures. Just before the baby's bath, they also pour, and lightly tap, a few drops of oil on the fontanel ("mole" or "*taru*") to prevent water and "air" from entering the skull and causing a head cold (see Springer 1979) The soft fontanel is considered vulnerable to "cold' and other elements because it is an "open" space in the skull where the bone-plates have not yet fused together Moreover, in bright light, the fontanel can be seen pulsating at a rate between the breathing rate and the rate of the heart. During tropical storms, the "exposed brains" of newborns are covered, and the head banded, to prevent mental derangement ('light-headedness') due to the thunderclaps. Though there is no danger in touching the soft spot which is covered by a membrane

as tough as canvas physicians say that the head and the fontanel should be left alone because peculiarities would disappear on their own (see also Illingworth 1988 Leach 1983, Llewellyn-Jones 1971, Nathanson 1994, Spock and Rothenberg 1985).[10]

Summary

Biomedical practitioners and traditional health care providers are not always in disagreement on certain medical concepts and practices. They both concede that breastmilk has anti-infective properties, that infants' breasts enlarge just after birth, that lactating women should consume large volumes of fluids, that sunlight is beneficial to newborn's skin, that gripe/colic is manifested by a "wringing" symptom, that oral infant thrush can be prevented by gently swabbing the inside of the baby's mouth, that heath rash is caused when sweat glands are blocked, that the umbilical cord should be swabbed with mentholated spirit, that *hassuli* is caused by an affected clavicle, that massage helps a baby to sleep sounder, and that mother and child should avoid being exposed to cold temperatures, and that gastroenteritis is characterized by diarrhea. Yet, very little attempt is being made by health administrators to accommodate traditional medicine/healers into biomedical praxis mainly because of the fear of competition against an established and influential medical elite.

Notes

[1] The consumption of vivine/bovine is also believed to have the desired effect of making the baby's skin become "clean, nice and pink."

[2] There are still many nutrients of human milk that are still unknown, and scientists, therefore, cannot reproduce them in artificial milk. Breastmilk has concentrations of carbohydrates, proteins and fats enzymes, vitamins and minerals Though cow's milk is the most commonly adapted milk considered as prototype for comparison with human milk, it varies in concentrations of proteins carbohydrates and fat, enzymes, vitamins and minerals The enzymes and the vitamin content in cow's milk are largely destroyed during pasteurization before being fed to children. Human milk contains two times more sugar than cow's milk. The sugar is largely lactose which is easier to digest than the galactose and glucose in artificial milk.

[3] The effectiveness of breastmilk as a treatment for eye ailments can be compared to the use of the sap (milk") of a freshly picked mango leaf-stem, seven of which are touched to the *bilat* or 'cattle boils' [an external cyst] in an adult person. The leaves are then hung over the fireplace to dry And as the leaves dry, the cyst drys.

[4] Elderly people maintain that there are fewer evil spirits nowadays because of the increase in the destruction of forested areas, and the number of electric lights throughout the country

[5] Camphor is also used as a remedy against cold and childhood asthma Some elderly informants, however, warned that since camphor is a "dangerous thing because it is heated," the caregiver should not bathe a child who is wearing camphor in his bag in cool/cold water or when the temperature is low (about 73° F) The placement of camphor in the cloth sachet should be done with precaution because "camphor can take away cold as well as give cold "

[6] Consecrated sachets, made by priests, are called "*jhantar* " by Hindus and "*tajij* " by Muslims The former includes Sanskrit or Hindu letters written over a geometric design on a piece of paper which is folded and kept as a locket as a means of spiritual protection (Vertovec 1992).

[7] *Jharayng* is also done to remove or neutralize venomous poison in the bloodstream injected by the bites and stings of snakes, spiders, scorpions and centipedes (Ramnath 1987)

[8] Elderly grandmothers and folk healers claim that freshly urinated "morning" urine, particularly of male infants, is also an effective cure for the common cold, sore throat, red/pink eye, poor eye vision and stomach pains People suffering from constant headaches are advised to wrap a freshly urinated diaper around their heads A newborn's urine is believed to be free of bacteria because "the child eh [not] eating any thing "

Some 600 doctors, scientists and therapists gathered recently in Panjim, capital of the southwestern Indian state of Goa, for the first World Conference on Auto-Urine Therapy (Graves 1996) Proponents of the urine therapy movement maintain thet urine is an effective cure for amebic dysentery eczema terminal cancer, skin burns, and eye injuries Urine contains urokinase, an enzyme thet is used to dissolve blood clots and treat heart attack victims Urine is also the main fluid in the amniotic sac In which the fetus floats for nine months

[9] Unlike postnatal caregivers in India (Luschinsky 1962, Williams and Jelliffe 1978), Trinidadian Indian women no longer apply the ash of burnt cow s dung on the raw end of the cord as is commonly believed by some Afro-Trinidadian nurses.

[10] Generally, opinions are divided among women of all racial and ethnic groups on the taboo of cutting the hair of a male infant before or after he begins to talk fluently Thirty-five percent of women say they do not believe that if the taboo is broken, the child would stammer throughout life, 65 percent—most of whom are Hindus—believe otherwise Some women argue 'That is a true thing, according to tradition.' Others say 'That wouldn t humbug the child from talking I cut my son' hair and look he [is] talking like a parrot.' For Hindus, the first hair-cut is done at the *chatti* [sixth day] ceremony or on Good Friday near the Roman Catholic church in Siparia where a statue of Virgin Mary is seen as a Hindu deity (see Klass 1988) Muslims cut the hair at the *aqueeka* birth thanksgiving ceremony, and money equal to the weight of the hair is distributed to the poor (see Karimullah 1981) For Muslims as well as Hindus, tonsure is symbolic of the cleansing of childbirth pollution ("belly-hair"), but it is also a kind of sacrifice as well as illustrative of a "new start" in life (McGilvray 1982.60)

CHAPTER 8
DISCUSSION AND CONCLUSION

In the wake of Structural Adjustment Policies (SAPs) prescribed by The International Monetary Fund (IMF) and the World Bank, Trinidad has embarked on a health sector reform program. Under this program, new imported technologies have made health care increasingly expensive to the growing number of unemployed people (MOH 1995). To alleviate this problem, the government should explore alternative approaches that depend less on costly disease-oriented hospitals, with sophisticated services from highly trained personnel, and more on traditional medical resources.[1] My research shows that these already satisfy the health needs of large sections of the population.

The Promotion of Industrialized Medicine

Since the establishment of the plantation economy in the Caribbean, countries, like Trinidad, have been exporting an agricultural or mineral commodity, and importing practically everything else, including food (Beckford 1975; Richardson 1992).[2] Caribbean people are eating more and more imported food and still use most of their land to grow coffee, bananas and sugar for export. The region still consumes what it does not produce and produces what it does not consume (Barry *et al* 1984). Since colonialism, the dependence on capitalistic countries for imported goods (Miller 1994; Singh

1989) has lead to the failure to develop the production of local resources, including the development of local health remedies Instead imported consumption patterns have developed which put pressure on the balance of payments, reduce local savings, increase local unemployment rates, and cause local resources for domestic use to remain idle or under-utilized The strategy of 'import-displacement' as a solution to the persistent economic dependence in the Commonwealth Caribbean, may well be applied to the health sector in cases where medication like imported rehydrant salt can be substituted for local coconut water The promotion of biomedicine at the expense of traditional medicine contributes to the maintenance and reproduction of foreign dependency (Singer 1990)

Under SAPs in Trinidad, both the provision and consumption of biomedical health services have become expensive, with the price of medication, in particular, skyrocketing (Martin 1989) In May 1997, the Minister of Health disclosed that the "Government could not and might never be able to find all the funds to satisfy all the demands of the population for health care" (TG 1997:8) He said Government, as a result, will have to look at alternative ways of financing the health sector to maintain, refurbish and build hospitals and health centers These "new and innovative options" as part of a "paradigm shift in health care" (Nanton 1997:9) include private sector collaboration, re-training of medical staff, upgrading of the ambulance system, and the introduction of user fees, a National Health Insurance system, and an information technology system[3]

Phillips (1994:148) predicts that "in the context of the difficulties associated with SAPs, we may find a return to traditional medicine as in Brazil, and a potential crisis in the region.' The return to traditional medicine is unlikely to happen in Trinidad, and elsewhere because, as my research has

shown, infrastructural determinants have taken its toll on the younger generation of "educated" baby boomers who are already addicted to biomedical drugs[4] Thus trend has been reinforced by the power of the media and other "authoritative' forces which, like physicians, have adopted a superior, vehement, and discouraging attitude to people who utilize traditional medicine. Press (1978 81) predicts that under severe competition from modern medicine, traditional medicine will decline in importance, but shift toward adjunct functions as in the treatment of chronic incurable or culture-specific illnesses

One public hospital administrator (Martin 1989 4) in Trinidad predicts that modern medical care will soon be beyond the reach of low-income groups in the country He points out that the capacity of public hospitals is bulging at the seams and suggested that changing personal lifestyles would be a 'more effective" alternative than maximizing the use of modern medical care Phillips (1994 148) has found that under the new national health policies in Trinidad, the rational which directs the public health care sector is the same as that which mandates the other sectors of the economy The result is a privatized health system based on profit maximization in which the major beneficiaries are the multinational health firms which are encouraged to operate locally In the United States, the main health system is undergoing an invasion of commercialization into an area formerly dominated by professionalism, the result of which is posing a severe risk to the care of the sick, the welfare of communities, the health of the public, and the public health (McArthur and Moore 1997)

Navarro (1976 206) points out that medical technology imported by underdeveloped and developing countries from industrialized countries is foreign to the parameters of Third World economies and sometimes do more

harm than good. Technology is a value-laden (and not value free) process in which cultural values are assumed and subsumed. Economic dependency goes hand in hand with medical dependency as cultural values are also imported from developed countries. The motive is to produce a society oriented toward a hospital-based, curative pattern of consumption with the "latest" in medical care. The concept of "a pill for every ill" gains quick currency as people depend more and more on physicians and drug treatment and less on proper diet, hygiene (McKeown 1979:169) and "other supportive therapy" (Fraser 1987:113). Within the Third World economy, a local hierarchy is formed according to racial, class and gender lines which replicates the divisions in capitalistic economies.

Levin and Idler's (1981) work on *The Hidden Health Care System* is more applicable to the Third World than capitalistic countries. They argue that

> [t]he time has come for a major conceptual shift in the health care policy debate, from viewing lay people as consumers of health care to seeing them as they really are: its primary providers ... in spite of the persuasiveness and importance of the lay resource in health care, it has been largely ignored in the current debates over health policy. One must assume that it is overlooked because it has been thoroughly taken for granted, even (and especially) by health planners, professionals, and policy makers, the principle participants in the debates. (Levin and Idler 1981:1)

They note, quite appropriately, that the power of the Western medical system "is great in displacing the indigenous healing systems in more traditional societies." Citing an example of corporate domination from the developed world, they observe that the response of hospitals and medical professionals to the increasing numbers of home births has been predictably negative because home birth constitutes a fundamental economic threat (Levin and

Idler 1981:98). Imported medical technology reduces the capacity of patients in the developing world to care for themselves with existing local resources (see McKeown 1979; Scheper-Hughes 1984). Alubo (1990) points out that in Nigeria that medicine has shifted from a philantrophic science in the service of humanity (*à la* Hippocrates) to a commoditized lucrative business and the public health program is being threatened by a growing trend of privatization. More than ever, he argues, medicine is being used by racial, gender and class interests in the society as a form of conquest, subjugation and subsequent domination.

The Biomedical Use of Traditional Medicine in the Caribbean

In the Caribbean, there have been few attempts to incorporate elements of traditional medicine into the formal health care system, whether as a means of decreasing clinical workloads or increasing acceptability and accessibility of services from the community (PAHO 1984). In 1963 in Guyana (formerly British Guiana), traditional religious forms of healing were integrated with modern psychiatric modalities (Singer *et al* 1967). The integration process was the initiative of an anthropologist who worked in an (East) Indian community, and who collaborated with the Director of the Mental Hospital and healers of Hindu/Indian-based Kali temples. At that time in the country there was only one London-trained Indo-Guyanese psychiatrist, responsible for patients in a hospital with an inpatient population of 500 to 800. He was also responsible for five outpatient clinics, scattered along the coast, where he saw about 2,000 patients monthly, 90 percent of whom were Indian.

The result of the collaboration witnessed a marked increase in the number of Indian admissions to the Mental Hospital, as well as an increase in the number of out-patients. Many of the patients came to the clinic because they were referred there by the native healers. Post-menopausal Indian mothers-in-law, who were thought to be free of involutional depression, attended the Mental Hospital for the first time.

> In practice, both healers and the people now make a distinction between Kali Work and Dactah Work. Kali Work refers to those affective reactions which respond to the cathartic, tension-release, and value reinforcement Kali techniques, which include, trance, rituals, sacred food preparation, beating of the possessed patient, standard dream analysis, family and community involvement. Dactah Work refers to the non-responsive organic and emotional disorders which are then treated by in-patient hospitalization, chemotherapy and electroshock therapy. Both chemotherapy and electroshock therapy have been enthusiastically received by the healers and patients as consonant with their own beliefs about magic and energy. Dactah Work and Kali Work effectively join in treating the patient and returning and keeping him in his family and community. (Singer *et al* 1967:111)

The Kali healers made frequent rounds to the Mental Hospital with the Director, who himself attended the major and some of the regular Sunday healing sessions. The Guyanese collaboration is interesting because it involved the process of "education" among a psychiatrist, an indigenous healer and an anthropologist whose roles and statuses were often blurred in the treatment of patients (Singer *et al* 1976:157). It is unfortunate that more use of traditional health resources are not utilized in developing countries plagued with shortages of biomedical staff, medication and equipment.

In 1972, the Jamaican government decided to train and employ approximately 300 Community Health Aides in the parishes of Hanover and St James (Kidd 1976; Marchione 1978:101-129). The aim was to give selected

older, stable women with little education a two-month training to enable them to work with low-income families in the area of basic health care, and equip them to motivate people to make use of family planning and other health facilities. It was envisaged that with their home and family commitments, they would remain in their districts after training. Training covered topics on basic anatomy and physiology, basic nursing theory, first aid, nutrition, maternal and infant care, family planning, personal and community health, common signs and symptoms of diseases, human relations and communications. Films, visual aids and role-plays were employed and health aides participated in dressing minor wounds, bed making and giving baths.

The target groups were women of childbearing age and adolescents. The important educational elements of the aide's task were to teach infant feeding and the advantages of breast feeding, and the importance of child spacing, to explain contraceptive methods, where such services could be obtained, to emphasize the importance of follow-up visits to the clinics for infant and child health services, and the significance of follow-up visits to Family Planning Clinics. The health aides worked under the supervision of the existing network of Public Health Nurses. The health aides first arrived in the field when the population was experiencing a scabies epidemic. Armed with highly effective lotion to treat scabies, the health aides were reportedly making a name for themselves, not merely as educators, but also quite literally as 'nurses'. The program was replicated in 1974, when school-leavers were trained as health aides, and in 1975 the Jamaican Government again decided to train 850 women to make a total of 1200 in the island.

The Jamaica's Community Health Aide Program was an efficient and concerted attack on the country's primary health care delivery problems,

particularly rural infant undernutrition The program also fitted into the overall, self-reliance strategy of first-aid work and preventative medicine and it also solved part of the country s employment problem (Marchione 1978) But the concept of the auxiliary health personnel, while new to the Caribbean, was already applied in rural and isolated areas in other parts of the world. Ecuador, for example, had a similar program in which traditional midwives were given one week of training to become 'volunteer collaborators The system, however, was not working well in the Indian communities because "instead of trying to build on and use positive elements of traditional practices, the health system [was] trying to co-opt the midwives and discourage the use of traditional practices" (PAHO 1984.3) Negative attitudes toward traditional beliefs and practices were very common among biomedical health personnel.

> Community members usually perceive such attitudes as a lack of respect toward themselves and this does nothing to foster a spirit of cooperation and participation. In countries with strong traditional health systems, there is a great potential for cooperation and sharing of elements between the traditional and modern systems to improve both participation and coverage, but to date very little has been done to realize this potential. (PAHO 1984.3)

The failure of the biomedical staff to understand and appreciate age-old traditions and customs resulted in alienation of the community The use of cheap labor in the field to promote the business of a medical industry, without making much use of existing local traditional knowledge or local physical resources, is not new to foreign economic enterprises in Jamaica, the Caribbean, or Third World countries (see Gonzalez 1975)

Clinical Studies of Traditional Perinatal Practices

Very little attempt has been made by physicians in developing countries to accommodate traditional medicine into biomedical praxis mainly because of the fear of competition. They are biased against even non-invasive medical traditional practices which are commonly described in the US as "psychic, "spiritual," "pranic," "paranormal" and "bioenergy therapy," and "mind-body healing." Generally, physicians in Trinidad ignore and condemn the positive effects of traditional treatments, and instead encourage the imposition of imported sophisticated therapeutics. Clinical observations increasingly indicate that some types of traditional or alternative medicine do seem able to cure or improve some medical conditions for which cosmopolitan medicine may not have an effective or acceptable treatment. Over 150 clinically controlled studies of healing have been published in the US, and more than half demonstrate significant effects on enzymes, cells in laboratory cultures, bacteria, yeasts, plants, animals and humans (Benor 1993:38-39). Electrocardiograms, for example, have shown that fetuses suffer less harm when mothers give birth in a squatting position—a delivery position considered as "primitive" by the modern medical practitioners (Vargas 1978:15).[5] When clinical observations show that traditional approaches are safe and effective with little or no side-effects, the biomedical paradigm can be expanded to include them (Mirozzi 1996, Simpson 1988).

The positive results on perinatal outcome of having an older woman present during labor and childbirth have been validated by six controlled studies (Klaus *et al* 1993, see also Chalmers and Wolman 1993, Raphael 1988). The clinical studies were conducted by different researchers in various hospitals in Guatemala, United States and South Africa to replicate the

benefits of a supportive lay person or doula.[6] The studies showed that fathers were themselves quite distraught and overwhelmed and were in no position to give the mothers the kind of undivided emotional support and encouragement needed. Spouses or male partners had to cope with fears for their partners safety and their baby's as well as dealing with their own confused emotions. In cases where an able mother or mother-in-law was not available, new parents sought the services of a doula who was present with the parturient woman during labor and delivery. The untrained, but experienced, laywoman was continuously present with the laboring woman and gave comfort, reassurance, and praise by touching (massaging, stroking, clutching, and holding) and by verbal communication. Like the traditional masseuse in Trinidad, the doula also goes to the home of the new mother to give physical and emotional support and perform light housekeeping and food preparation duties.

In the studied doula group, more women delivered vaginally without the use of anesthesia, oxytocin, medication or forceps. The mothers with the shortest duration of labor in the study were again those women who had a doula present. In the doula group, only eight percent of the mothers asked for or required an epidural compared to 55 percent of the mothers in the no-doula group. The mothers in the doula group also had a reduced rate (7%) of cesarean sections in contrast to the no-doula group (17%). Oxytocin augmentation was used for two percent of the experimental doula group compared to 13% for the control group (Nolan 1995 13). In the study done in the Guatemalan hospital in 1980, there were significantly fewer perinatal problems (37%) in the experimental doula-supported group than in the control group (76%) (Nolan 1995 12). Doula-supported mothers were more affectionate, attentive and responsive to their babies immediately after birth,

and they showed a lower score in measures of depression than women with no doula The doula-supported group was also more likely to breast-feed their babies exclusively at six weeks and feed on demand rather than by the clock (Klaus *et al* 1993)

In many traditional cultures, a birthing woman is/was always supported during labor by a female family member or friend. The point that should be stressed is that obstetricians should not overlook traditional (noninvasive) methods of therapy in their haste to intervene with the aid of drugs and expensive imported technology (Raphael 1988) Indeed physicians should not resort to technological and pharmacological interventions when nature can take its own course in the curing of an illness (see Rosen 1991) Birth is a physical, emotional, social and cultural event, and to concentrate on one of these elements at the expense of the others is counterproductive Obstetricians should also be sensitive to the the view that birth is a natural and not medical event, in which female companions should be given an opportunity to express empathy with their own sex during this rite of passage. The medical costs for maternity services when doulas are introduced into labor wards could be reduced significantly (Nolan 1995) Anesthesia costs would be lessened significantly, operating room expenses would be reduced considerably, the high use of epidural anaesthesia and caesarean sections would be cut, and extended hospital stay would be shortened

My research among postnatal women in Trinidad show that the majority (67%) of them would have preferred a relative to be present in the delivery room. Many of them confessed that they felt lonely, unsafe and scared in the cold delivery room and in the presence of strangers in gowns Research (Kennell *et al* 1991 2201) has shown that maternal anxiety increases the level of catecholamine which decreases uterine contractility and uterine

blood flow Hospital policy in Trinidad, and elsewhere, which does not allow a laboring woman to be accompanied by any other person except official staff should be changed to include at least one supportive woman who should be present from admission until delivery Traditional masseuses are the best candidates to be assigned to laboring women in the maternity wards in Trinidad because of their experience in treating parturient women Local hospital nurses, on the other hand, are the most unlikely persons to give emotional support to laboring women because of reported strict unfeeling attitude, especially to unmarried teenage and Indian mothers

Clinical studies at the Touch Research Institute[7] at the University of Miami have shown that when premature infants are massaged, they gain 47 percent more body weight (Field *et al* 1986, Miller 1992, Colt 1997) Later studies show that massage stimulates the release of food absorption hormones, which allows the infants to extract more nutrients from their diet (Viliano 1992.32) The massaged infants were more active and responsive during sleep/wake behavior observations, and slept more soundly They also showed more mature habituation, orientation, motor activity, alertness and range of state behaviors on the Brazelton scale Massaged infants also scored higher on an "IQ test" that measured reactions to social stimulation. Their hospital stay was six days shorter in the neonatal intensive care unit, producing a cost of approximately US $3,000 per infant The Institute researchers are currently investigating a wide range of applications for touch therapy which includes the use of massage in enhancing the immune system in AIDS and cancer patients, and in decreasing the duration of labor during childbirth and reducing the need for medications. The female director of the Institute argues that

> [w]estern medicine has largely overlooked research into the sense of touch because of the great advances in surgery and drug therapy made during this century (Villano 1992:35)

Shands Hospital at the University of Florida also uses massage to relax newborns in the afternoon. The pediatric unit of the teaching hospital has adopted a 'humanitarian approach to medicine by treating the "whole person" (Washington 1997:33) through its Arts in Medicine program (Graham-Pole *et al.* 1995; McLeod 1995).

The Project's Recommendations

Many Third World government health ministries do harm to themselves by officially ignoring traditional medicine and the potential for its partial or full incorporation in health care planning (Good *et al* 1979). Paul (1955:69) identifies a common problem of many public health programs as the 'fallacy of the empty vessels,' the preconception of health professionals that people do not already have their own established beliefs and practices and are 'empty vessels,' waiting to receive scientific ideas and whatever a biomedical practitioner advocates (see also Adair and Deuschle 1970, Polgar 1962). The truth is that health care is not a service that can be simply imposed from above/abroad on a mistakenly passive island community. A practical approach would be to include beneficial elements of traditional medicine in the formulation of national health policies.

PAHO's (1984) definition of "self reliance" certainly does not mean self-care and the reliance on locally-derived methods of therapy which utilizes traditional knowledge---a departure from the commercial products produced by multinational corporations and sold by pharmacists and even privately-operating physicians themselves. Self-reliance should mean exactly

what it is--the utilization of local resources (see Harrison 1981) and traditional knowledge by people in a well-informed manner in pursuit of their own total well-being (see Carr 1984) The empowerment of people in developing countries should be established on the following principes: (1) providing an opportunity to exchange information about sickness and health with biomedical personnel, (2) allowing their voices to be heard in discourses on policy implementation, and (3) giving them control over their own cultural and material resources. Rather than empowering people by providing them with modern information, foreign technology, technical support, and decision-making possibilities, PAHOs recommendations would weaken people by disregarding their traditional knowledge, beliefs and practices

Biomedical and anthropological researchers need to determine which elements of traditional medicine are (a) beneficial, (b) harmless (c) uncertain and (d) harmful (Verderese and Turnbull 1975, Williams and Jelliffe 1978) Those traditional practices thet are beneficial or positive to health should be actively adopted in health education and practice These practices include the consumption of certain protein-rich foods during pregnancy and the puerperium. Cow's milk, for example is considered by masseuses and grandmothers to be "nourishing" to the "open" bones and joints of new mothers, and should be drunk daily to increase the production of breastmilk. Also found to be beneficial by physicians is the period of convalescence in which the new mother is given the opportunity to bond with her baby Another example is the notion of postpartum exercise done to firm the abdomen, tighten the pelvic floor muscles, stimulate blood circulation, and aid in the healing of sutured episiotomies. Sitz bath with boiled salt water is another traditional medical practice which has found favor with the medical community It is recommended both as a prophylactic measure and as a

means to reduce the risk of bacterial infection Maternal and infant massage and sun-walking of the infant have been recommended by biomedical researchers Health educators are yet to make use of the society s conception of folk concepts like the hot-cold and open-close dichotomy, as well as the stigma attached to bearing a *lamárya* child born within one year of the last sibling.

There is the need to conduct multidisciplinary investigations into all aspects of traditional medicine in Trinidad and elsewhere (Bannerman 1977) Psycho-social and anthropological approaches must be included in these investigations Special attention should be given to laboratory and clinical tests to identify the therapeutic results of selected medicinal plants, animal products, and mineral substances. In the Third World where technological resources are limited, people should not be "educated" to discard their traditional therapeutic practices unless these measures have been proven to be absolutely dangerous to their health (Banerji 1984 274) Too often there is the tendency to denounce all traditional practices in a *carte blanche* fashion by medical practitioners (Harrison 1981) Professional medical control tends to mystify and expropriate the power of lay people to heal themselves and to shape their own environment (Illich 1976)

Harmless traditional practices which do not have any obvious ill effects, but which have positive psychological efficacy should at least be tolerated by biomedical practitioners These traditional practices may include abstaining from cutting the hair until the child can talk, or attaching an amulet to the newborn's clothes to prevent the evil-eye Non-invasive therapeutic measures which have positive psychological effects, such as meditation and prayers, also fall in this category Uncertain traditional practices, which can be defined as those with possible beneficial as well as

harmful effects, can be ignored by the biomedical community. This category may include the use of certain herbs. These customs, for which different interpretations are possible, should also be unopposed pending further observation and empirical study. Harmful traditional practices having deleterious effects, as far as health is concerned, should be discouraged. One example in this category is the use of a urinated diaper to treat oral thrush. Harmful practices should be the main source of concern for Maternal and Child Health personnel and will require modification by friendly persuasion and convincing demonstration (Williams and Jelliffe 1978).

International agencies, like PAHO, have noble ideas of community participation and education as two key components of primary health care provision in developing countries. The rational for such proposal is that "communities must assume increasing responsibility for their own health, and to this end health education will provide the necessary knowledge to enhance the concept of self-care" (Carr 1984:32). Community participation, according to these agencies, should take the forms of NGOs in which members are trained as health workers and health facilities are either built or refurbished (see Harry-Ashley 1989). Health care

> must be generated from within the community itself and must be a response to the demands from the community. In addition, a spirit of self-reliance must be developed at the individual, the family, and the community levels in the pursuit of the goal of health for all. (PAHO 1983:21)

PAHO's notions of "community participation" and self-reliance" are limited to a Western-based biomedical model in which it is assumed that community members have to be "educated' because they have no knowledge of treating even minor ailments appropriately. WHO's proposal (Bannerman 1977) to mobilize the manpower component of traditional medicine to contribute to

primary health care provision in developing countries has not gained much ground in the Caribbean.

Clinical studies of the benefits of the *doula*, and massage of the preterm neonate, have demonstrated that while much emphasis has been placed on medical technology, little attention is given to traditional techniques of healing. True "health care for all" can only be achieved when researchers study, understand, and--where appropriate--incorporate traditional and alternative medical practices into their repertoire. Past experience has shown that there has been little attempt to build on, or incorporate, "old-fashioned" medical beliefs and practices into biomedical training or health programs. Rather, the attempt has been to understand them so that policy-makers can eradicate (Illich 1976)[8] and replace them with physician-sanctioned behaviors. It is commendable that many hospital personnel in Trinidad at least tolerate the rituals of priests and other spiritual healers in the wards during visiting hours. Biomedical personnel[9] should seize the opportunity to enlighten these healers on how to recognize some of the crucial signs and symptoms of certain illnesses and to encourage them to refer patients to visit the hospital when the need arises. By adopting this open attitude, a truce can be reached between physicians and traditional healers, and the general population would be able to enjoy the best of both worlds.

Summary

My study has shown that traditional medicine is a phenomenon that has persisted with vigor across ethnic lines in an urban area in Trinidad. The main problem in harnessing this local resource, as a way of supplementing government health care services in a developing country (WHO 1977, 1978a,

1978b), lies within the state health care system which is based solely on a dependent capitalistic model. The aim of the government should be to recognize useful elements in the traditional medical system, and to incorporate these as part of its national health plan. The present public health system should make more use of existing local and natural resources--as is being done with breastmilk, sunlight and coconut water--in the therapeutic process of self-medication. My proposed model also advocates the maximum use of traditional healers and/or their therapeutic practices which would minimize the dependency on Western medical services and medication (see Scheper-Hughes 1884). I support a new culture-sensitive health care strategy based on popular participation in which primary health care is provided "by the people" using their own resources, as opposed to health "for the people" which is based on a hospital-delivery model (Anderson and Staugard 1986, Gish 1979).

Notes

[1] At the moment of writing, groups of Trinidadians are traveling to a recently-erupted volcano in the island to collect sticky gray mud. The self-application of the mud is believed to "improve" the complexion of women's skin [to give a fairer, cleaner appearance], and is believed to be effective in the treatment of arthritis, backache and bodily ailments. The biomedical community has discouraged its use until scientific research is undertaken (TE 1997 25).

[2] "Street hawkers sell Washington apples in Haiti, tissue-wrapped pears in Trinidad, and Georgia peanuts in Barbados. Yet it is often difficult to find yams, fresh vegetables, or fresh fish for sale in the street markets of Caribbean cities" (Barry *et al.* 1984 7).

[3] Trinidad's annual health budget is about TT $700 (US $112 million), with payments of health surcharges by the working population contributing TT

$100 to that total (Nanton 1997:9). The Health Minister disclosed that about 10 000 patients pass through the Accident and Emergency Department at the nation's hospitals on a daily basis (TG 1997:8).

[4] "Further increases in formal education and in medical services in the island, together with a greater use of proprietary medicines, will help to decrease the popularity of the old Creole remedies. Folk medicine in Trinidad has lost some ground, and what remains is changing, but for some time it will continue to be functional in the lives of many lower class Trinidadians" (Simpson 1962:20).

[5] During midwife training programs in Guatemala in 1952 and 1978, most traditional practices were condemned, including the use of herbs, the sweatbath and the kneeling or squatting delivery position (Cosminsky 1982).

[6] Doula is a Greek word referring to an experienced woman who guides and assists new mothers during childbirth and postpartum.

[7] The Institute, established in 1992, is the world's first research center devoted solely to understanding the role of touch therapy in human health and development. It is staffed by a multi-disciplinary faculty of experts including pediatrician Dr. T. Berry Brazelton, and Princeton anthropologist, Ashley Montagu.

[8] Singer (1990b) argues that most applied medical anthropologists have been guilty of facilitating the introduction of Western biomedical health care into the improvished developing world. He adds that the global impact of capitalistic development on local people's health behavior remained a neglected theme in anthropology for a long while.

[9] Pharmacists in Jamaica are more open than doctors to folk concepts and beliefs. They are highly utilized by patients who purchase pharmaceuticals used for self-medication and home-treatmnent, and who do not have the capacity to pay for the services of a private physician (Mitchell 1984).

APPENDIX A
LETTER OF PERMISSION FROM HOSPITAL

1994 May 24

Prof Syan Reopnarinesingh
Medical Chief of Staff
Mount Hope Women's Hospital
Uriah Butler Highway
CHAMPS FLEURS

Dear Prof Reopnarinesingh,

This is to introduce Dr. Kumar Mahabir about whom I had previously written to you As indicated, he is interested in doing field research on postpartum woman

I have discussed with him your recommendation and he is interested in taking up your offer, i e the provision of names and addresses of woman who have delivered at the Mount Hope Women's Hospital.

I have asked him to arrange an appointment with you to have further discussions

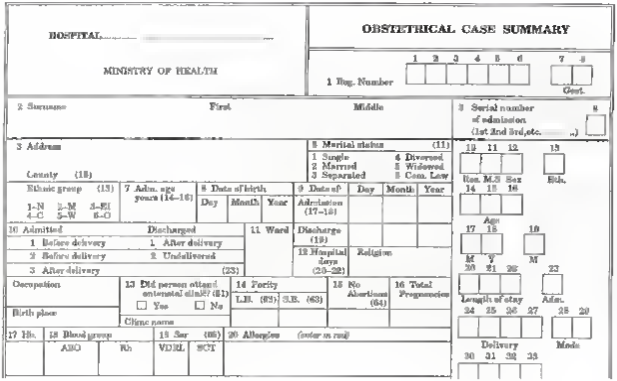
Yours sincerely,

For and On Behalf of
ERIC WILLIAMS MEDICAL SCIENCES COMPLEX
A HOSPITAL OF THE CENTRAL REGIONAL HEALTH AUTHORITY

RASHEED RAHAMAN, F.R.C.P
MEDICAL CHIEF OF STAFF

Medical Records Office
Can Prof S please
Please cooperate with
this project
Thanks
S

APPENDIX B
HOSPITAL OBSTETRICAL CASE SUMMARY FORM



HOSPITAL.....

MINISTRY OF HEALTH

OBSTETRICAL CASE SUMMARY

1 Reg. Number 1 2 3 4 5 6 | 7 8 Genl.

2 Surname | First | Middle

3 Address

County (18)

4 Marital status (11)
1 Single 2 Married 3 Separated 4 Divorced 5 Widowed 6 Cons. Law

5 Serial number of admission (1st 2nd 3rd,etc. ....) 9

19 11 12 | 13
Res. M.S. Sex | Bldg.

Ethnic group (13)
1-N 2-M 3-Pl
4-C 5-W 6-O

7 Adm. age years (14–16)

8 Date of birth: Day | Month | Year

9 Date of Admission (17–18): Day | Month | Year

14 15 16
Age

17 18 | 19
M Y | M

20 21 26 | 23
Length of stay | Adm.

10 Admitted: 1 Before delivery 2 Before delivery 3 After delivery
Discharged: 1 After delivery 2 Undelivered (23)

11 Ward

Discharge (19)

12 Hospital days (20–22)

Religion

Occupation

13 Did person attend antenatal clinic? (21) ☐ Yes ☐ No

14 Parity: L.B. (27) S.B. (63)

15 No Abortions (64)

16 Total Pregnancies

24 25 26 27 | 28 29
Delivery | Mode

30 31 32 33

Birth place

Clinic name

17 Rh. | 18 Blood group: ABO | Rh | 19 Ser (66): VDRL | SCT

20 Allergies (enter in red)

21 Complications during pregnancy and associated diseases (Specify) (34–37)

Other Delivery
34 35 36 37

LABOUR AND DELIVERY

Pregnancy
38 39 40 41

(38) Gestation period (wks.) 25 Normal Delivery

(7–8)

Post partum
42 43 44 45 46 47

OP 1 OP 2

48 49 50 51 52 53

Disch. Death

54 55 56 57 58 59 60

Age D—List

61 62 63 64 65

Ante LB SB Aber Ser

66 67

N NBS

68 69 70 71 72 73 74

N Abn. Pre SB

75 76 77 78 79 80

Emerg. Year Card

IN CASE OF DEATH, COPY OF DEATH CERTIFICATE TO BE ATTACHED

(39) Mode of delivery (39–33) *(Enter/mark all numbers that apply)*

01 Spontaneous
11 Vertex, initiated
12 Vertex, assisted
13 Breech assisted
14 Breech extraction (without instruments)
20 Forceps, mid
30 Forceps outlet
40 Forceps, other coming head
49 Forceps, unspecified
50 Vacuum extractor
60 Caesarean section
61 C.S. with intact fundus
62 C.S. with hysterectomy
71 Craniotomy
72 Embryotomy
80 Surgical other
90 Unspecified type

37 Complicated delivery (34–37)(39–33)

00 No complications
01 Placenta praevia
02 Placenta retained
04 Placenta, discased
05 Haemorrhage, antepartum
06 Haemorrhage, intrapartum
07 Haemorrhage, antepartum
08 Abnormal body palvis
09 Pathogenic disproportion
07 Prolonged labour (30 hrs)
08 Umbilical cord com.
09 Previous Caesarean sec.
10 Rupture of uterus
11 perineum/ uterus
12 Laceration of cervix
13 Laceration of perineum
14 Anaesthetic death

28 Condition of placenta ☐ Normal ☐ Abnormal (Specify)

29 Perineal tear (Check one)
2 2d degree (fourchette muscle)
3 3d degree (fourchette muscle)
1 2 st degree (slight) sphincter uni)

30 Postpartum period ☐ Normal ☐ Complimted (Specify)

(38–41)

31 Breast Feeding at Discharge

☐ Yes ☐ No

32 Surgical procedures

OP 1 (42–44)

OP 2 (45–47)

33 Result of delivery (63–71)

Birth Seq	Sex	Birth-Weight in grams	Live birth Nor	Abn.	Prem.	Still Birth
1st						
2nd						

34 Discharge status of mother (66)

9 Delivered
0 Undelivered
2 Improved
3 Not improved
8 Dead no autopsy
9 Dead autopsy

35 Type of discharge of mother (49)

1 With approval
2 Against advice
3 Absconded
4 By transfer
9 Other
9 Death

Signature Date Signature Date

APPENDIX C
ETHNO-BOTANICAL DATA

bird pepper	Solanaceae	Capicum frutescens	fruit	evil eye
caraille	Curcurbitaceae	Mormordica charantia	fruit, leaves	bath, abortion
congolala	Compositae	Eclipta alba	leaves	bathwater, cough
doob	Graminaceae	Cynodon dactylon	leaves	jaundice
fever grass	Gramineae	Cymbopogan citratus	leaves	bathwater, colds
ganja/marijuana	Cannabidaceae	Cannabis sativa	leaves	female fertility
ginger	Zingiberaceae	Zingiber officinale	rhizome	breastmilk production
guava	Myrtaceae	Psidium guajava	leaves, bud	bathwater, diarrhea
hardi/tumeric	Zingiberaceae	Curcuma domestica	rhizome	breastmilk production
hogplum	Anacardiaceae	Spondias mombin	leaves	sitz bath
mint	Labiatae	Hyptis atrorubens	leaves	gripe/colic, dysentry
nutmeg	Myristicaceae	Myristica fragrans	seed	gripe, colic
St. John bush	Acanthaceae	Justicia secunda	leaves	bathwater, skin rash
sweet broom	Scrophulariaceae	Scoparia dulcis	branch	evil eye
vivine/vervine	Verbenaceae	Stachytarpheta jamaicen	leaves	breastmilk production
zeb-a-pique	Compositae	Neurolaena lobata	leaves	bathwater, fever

APPENDIX D
HALWA RECIPE

This dish is prepared and eaten only during the *chhati* and *barahi* (6th and 12th day after childbirth respectively) celebrations. It is offered first by the mother of the child to the appropriate deity, and then served to the guests at the ceremony.

Ingredients

8 ozs / 225 grms sifted white flour
8ozs / 225 grms granulated sugar
1 oz / 25 grms halwa/hulwa *massala*
2 ozs / 50 grms freshly grated ginger
1/2tsp / 1/2 of 5 ml spoon whole grain *geera* (cumin)
1-1/2ozs / 38 grms *ghee* (clarified butter)
1/2pt / 300 mls evaporated milk, and
1/6 pt / 100 mls water (to mix *massala*)
1-1/6pt / 700 mls water for additional use

Method

- Parch flour in an iron pot on medium heat for about 5-6 minutes
- Allow to cool and sift into a fairly large mixing bowl
- Mix flour with ground ginger and sugar
- Add milk and 1-1/6 pints water to flour and, using hands stir until mixture

is smooth.

- Heat *ghee* and add *geera*
- Mix halwa *massala* in 100 mls water
- Add to pot and fry for about 10 minutes on a very slow heat, stirring pot constantly
- Stir flour mixture and add to pot
- Keep turning until all the liquid has been absorbed

Serve with *dosti roti* or as a side dish

Serves 10-12 persons
Halwa massala preparation

If you are making your own halwa massala, you have to combine massala *hardi* (tumeric), ginger and jawine and grind on a sil

If you are using the prepared halwa massala from the store, you should follow instructions given on the label

Source: Mahabir 1992

APPENDIX E
CELEBRATORY CHILDBIRTH SONG

jaba more lalwa ke ninda lagat hei	when my son feels sleepy
palana dea mangai	I'll want a hammock
dea lalka	for my son

jaba more lalwa ke bhuka lagat hei	when my son feels hungry
jaba more lalwa	I'll want *barphi* and *jileb* [sweetmeat]
ke bhuka lagat hei	for my son

jaba more lalwa	when my son's
bakhaiya chele hei	feet are creeping
chate se ghungru mangai	I'll want small *ghungrus* [anklets]
dea lalko	for my son

jaba more lalwa	when my son
dulahin mangai hei	wants a bride
choti se raniya	I'll want a small princess
mangai dea lalka	for my son

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BIOGRAPHICAL SKETCH

Kumar Mahabir earned his BA. and M.Phil. degrees in English at the University of the West Indies. His M.Phil.s thesis is entitled "East Indian Folk Songs of the Caribbean."

He worked as a High School English/Literature teacher and a television cultural documentary producer and presenter in Trinidad before attending the University of Florida.

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I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate in scope and quality, as a dissertation for the degree of Doctor of Philosophy

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This dissertation was submitted to the Graduate Faculty of the Department of Anthropology, in the College of Liberal Arts and Sciences and to the Graduate School and was accepted as partial fulfillment of the requirements for the degree of Doctor of Philosophy

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